FOCAL PSYCHOTHERAPY

An Example of Applied Psychoanalysis

Michael Balint,
Paul H. Ornstein
& Enid Balint

MIND & MEDICINE MONOGRAPHS

Founded by
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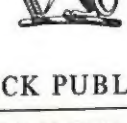

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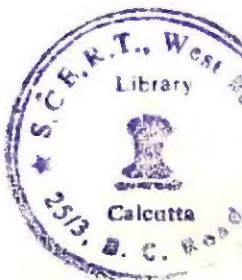

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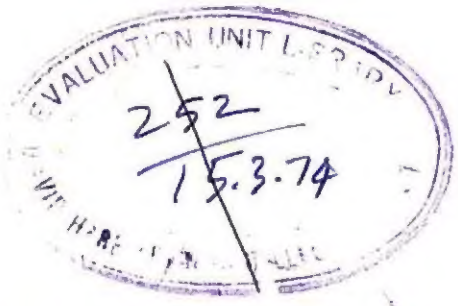

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Preface

The bulk of the work presented in this book was complete at the time of Michael Balint's unexpected death on 31 December 1970. He had still to write Chapter 4 ('General Structure of Focal Therapy: Use of the Forms') and parts of Chapters 3 and 9, which were subsequently completed by Enid Balint. Chapters 2, 7, and 10, the outline and main emphasis of which were discussed during our work together, were my responsibility to complete. This was done after some additional consultation with Enid Balint.

To my profound regret, we no longer had a chance to submit these chapters to Michael Balint's critical review – which on each occasion had invariably led us to new and unexpected insights.

This book is based on Michael Balint's treatment of Mr Baker, written by him (Chapter 5). Unfortunately, the comments at the end of each session report are 'asymmetrical'. The reader should be aware that Michael Balint dictated his notes right after each session and that originally these notes were not meant for publication. He later decided to include them in their original form with only very minor stylistic and grammatical changes here and there.

As the joint work progressed, various agreements, some differences of opinion, and some differences in emphasis became clear. Michael Balint then graciously suggested that each of us sign those chapters for which we bear primary or sole responsibility, to avoid having to cramp our respective ideas into a watered-down compromise.

Enid Balint was an active participant, contributor, and effective critic during the work on this book. After her husband's death not only did she supply Chapter 4, as mentioned above, but she also undertook to advise on the entire book.

Dr Mary Hare kindly volunteered to read through the whole manuscript of the book before Michael Balint died and we are most grateful to her. She has also helped us with the reading of the proofs.

Paul H. Ornstein, MD

Cincinnati
May 1971

CHAPTER 1

Introduction

As the time-table in Chapter 5 shows, the treatment on which this book is based was terminated on 11 February 1962. The patient was then followed up systematically by letters and by further interviews until 25 December 1966. However, the contact between the patient, Mr Baker, and the therapist, Michael Balint, has continued. The patient, as will be seen, still turns to him when there is a realistic need for it. What was the reason, then, that this material had to wait until 1970 to be reported?

We, the two authors, met fairly regularly in Cincinnati from 1956, at which time one of us (PHO) was in training there – he is now on the faculty of the Department of Psychiatry – and the other (MB) was made a Visiting Professor of Psychiatry there, and has since returned to Cincinnati at fairly regular intervals. It soon became clear that the two of us had similar views and ideas about both the analytic-therapeutic process and the processes obtaining in the various forms of psycho-therapy. Research on focal therapy was, of course, one of the topics often discussed by us, at least since 1960.

Mr Baker's treatment was first mentioned in our discussions early in 1968 as an illustration of problems in therapeutic techniques. The following year the two of us met in Rome at the Twenty-sixth International Psycho-Analytical Congress, where one of the symposia was on short-term therapy. We were both disappointed in the arbitrary demarcation of the topic and the manner in which it was approached.

Under the impact of this shared emotional experience Michael Balint proposed a joining of forces to prepare this material for publication. This would be an excellent opportunity to express our views, a task that Michael Balint felt he would not be able to undertake alone.

I welcomed the opportunity of getting better acquainted with the techniques and theories relating to focal therapy while working over the material with Michael Balint. Then and there we decided to spend the next summer vacation on this work.

This chapter was completed by Paul H. Ornstein after Michael Balint's death.

Our aim, as it developed during the joint work, is to use the history of the treatment of Mr Baker to study in detail the interactions between the patient's associations and the therapist's choice of interventions. From the theoretical point of view this interaction can be summed up not only as the study of the treatment as a process, but also as a study of the developing doctor–patient relationship. The first aspect belongs to the theory of technique, and the second to the general field of the theory of object relationships.

The material for this study is the collection of session reports, which were as a rule dictated to a secretary immediately after each session. No notes were made during the treatment sessions. The therapist relied entirely upon his memory. We know that this method has many drawbacks, and a number of purists will find it inadequate for meaningful research.

We readily admit that in a way recall from memory is not as reliable as a record on tape. On the other hand, we maintain that the internal cohesion within both any single session and the whole series of sessions taken together is enough to demonstrate the validity and usefulness of this particular method. In Chapter 4 we shall discuss this important point further.

Here we would only like to indicate that the method of recording used in this treatment facilitates the clear emergence of both the patient's character and the nature of the therapeutic technique, whereas otherwise both would have to be laboriously extracted from the collection of raw data provided by tape-recordings. Furthermore, no tape-recording can give any information about 'interpretations thought of, but not given', the atmosphere of the session, the therapist's initial expectations, or his changing views regarding outcome and his afterthoughts and so on; on the other hand, all these important data are provided by the design of the method used.

The patient's letters to the therapist show that the picture of the patient's personality as it emerges from the session reports tallies with that emerging from his letters to the therapist.

We have said that our chief aim is to study the interaction between patient and therapist. Here, our concern with the proof that focal therapy leads to acceptable therapeutic results is only secondary. The validation of the results from the first twenty-one cases treated by the Focal Therapy Workshop has been published by Malan (1963). Furthermore, he is at present preparing a critical study of the

therapeutic results of all the patients treated, amounting to about fifty cases. Therefore, we feel free to deal with the techniques and processes of this form of therapy and to use Mr Baker's treatment merely as an illustration. However, it should be stated that Mr Baker's illness was a severe jealousy paranoia, diagnosed as such by his family physician and by a consultant psychiatrist. Both seriously considered hospitalization and were greatly relieved when therapy was offered. Mr Baker received twenty-seven sessions over a time-span of about fifteen months. He was followed up for about four-and-a-half years directly by the therapist, and indirectly through reports from the general practitioner for about another two years—a total of six-and-a-half years.

CHAPTER 2

Some Antecedent Forms of Brief Psychotherapy

Malan (1963) and Small (1971) have recently reviewed and evaluated brief forms of psychotherapy. This outline is merely intended to put 'focal psychotherapy' in perspective once more by indicating some of its antecedents.

Only those forms of brief psychotherapy will be mentioned here that have developed directly out of psychoanalysis. These will be considered only in so far as they might shed some light on the similarities and differences between these antecedent forms and Balint's 'focal therapy' and will thus highlight his specific contributions.

Balint's theory and technique have further evolved since the Focal Therapy Workshop (see Chapter 3) and since Malan's work was published (1963). The patient whose focal therapy (see Chapter 5) serves here to illustrate the evolution of Balint's own thinking was not seen until the end of 1960 and is thus not included among the twenty-one workshop patients on whose treatment between 1955 and 1958 Malan based his studies.

For a glimpse at those antecedents already referred to we have to go back as far as the *Studies on Hysteria* (1895). These studies clearly show the evolution of what later became known as psychoanalytic technique. From the point of view of tracing the development of this technique, the value of the *Studies* lies in the fact that Freud is explicit about: (a) his ideas of the pathological condition under treatment; (b) the various interventions used in the therapy of each of the patients described; and (c) the response of each patient both to Freud's planned and to his inadvertent interventions. Thus one is able to follow Freud as he changes his technique in response to his increasing understanding of the nature of psychopathology and of the nature of therapy as he moves from one patient to the next. From this kind of

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reporting. it is easy to discern the evolving rationale for therapy and to follow Freud's logic — along with the empirical data on which it was based — to the point where we can begin to talk about psychoanalysis.

It is in these *Studies* that we find the first published, short-term, analytically oriented psychotherapy, in 'Katharina'. Freud reproduced the dialogue between Katharina and himself in a manner that unfolds the clinical history, his own diagnostic and interpretative interventions, and Katharina's responses to them. In these responses, beyond the mere agreement, disagreement, or slight evasion of the answer, the appearance of new, confirmatory material permits Freud to reconstruct the events and the psychic processes leading to the hysterical anxiety symptoms. Even such details as the appearance and the meaning of one of the symptoms, vomiting, and the identification of the 'hallucinated face' were properly reconstructed. As a result of this reconstruction two sets of important memories emerged that, chronologically, preceded those that seemed immediately responsible for the symptoms for which Katharina asked for Freud's help. Freud remarked in his discussion that 'the patient agreed that what I interpolated into her story, was probably true; but she was not in a position to recognize it as something she had experienced.' Nevertheless, Freud described Katharina, after she told him of her memories, as follows: 'The sulky, unhappy face had grown lively. Her eyes were bright. She was lightened and exalted.' Thus this *one* encounter resulted in an effective relief and in a noteworthy change in her entire demeanour. But for how long?

A follow-up on Katharina would be very important. The circumstances did, of course, prevent it and therefore we do not know how Katharina responded in the long run to Freud's brief 'analysis'.

Unfortunately, well-documented treatment processes and adequate follow-up studies of psychoanalysis or psychotherapy are still not available. Malan (1963) discussed this deficiency in psychotherapy research extensively, and proceeded to remedy the situation with his own studies of outcome and follow-up. However, he did not include a much needed study of the technique used by each therapist in the workshop.

As psychoanalysis was becoming an ever lengthier and more complex therapeutic procedure, the early analysts, while still engaged in brief therapy, reported only very few such cases in the literature and followed up even fewer of them. Malan found only seven published reports (in 1963) of brief therapy between 1909 and 1914. Follow-ups

were rare or non-existent, though the patients of these early analysts did not live in inaccessible mountain huts as Freud's Katharina did.

During and after the First World War the need to find shorter forms of psychoanalytic therapy was recognized. The necessity arose from both internal and external sources. The internal sources had to do with the fact that the lengthier and more complex psychoanalytic treatment also gave rise to the recognition of new problems, new obstacles to analytic cure. Since the lengthening of the analyses and some of the concomitant difficulties were, in part, credited to the analyst's 'passivity', shortening of the analyses and counteracting the analyst's passivity seemed a logical remedy. Ferenczi (1919, 1920, 1925) was foremost among those, perhaps even the first, aside from Freud himself, who experimented with new approaches to resolve the newly found technical problems in treatment. Ferenczi's so-called 'active technique' is pertinent to our brief historical considerations, and we will soon return to it.

Freud, of course, always responded to new empirical data in his day-to-day clinical practice with innovations in both theory and technique. On this occasion, however, he also responded sensitively and with incredible foresight to the demands from without: society's needs for the availability of treatment for a larger segment of the population. In this paper before the Fifth International Psycho-Analytical Congress in Budapest in 1918 (Freud, 1919) he envisaged greater demands upon analysis as a therapeutic process. He reviewed the current status of analytic technique and commented on Ferenczi's 'active technique' (1919) as the possible avenue along which psycho-analysis would further develop.

In addition to discussing the analytically advisable limits of the analyst's activity, Freud felt that the necessary and desirable shortening of the therapeutic process might also make use of such 'activities' to make psychoanalytic therapy available on a large scale, by state-supported outpatient clinics, free of charge. Freud has accurately anticipated society's needs and demands, which have been increasing ever since and still continue to increase.

How is it that so few analysts have taken up this challenge of developing a systematic and therefore definable, teachable, and researchable form of brief psychoanalytic psychotherapy? The answer to this question is multi-faceted and is examined in detail elsewhere (Ornstein, 1970a; Ornstein and Ornstein, 1969). It is very likely that

Freud's closing comments in his Budapest address contributed to the analysts' aversion to briefer forms of therapy. This is what most analysts remember of it: 'It is very probable, too, that the large-scale application of our therapy will compel us to alloy the *pure gold* of analysis freely with the *copper* of direct suggestion . . .' (italics added). Few analysts recall the last sentence that immediately follows: 'But, whatever form this psychotherapy for the people may take, whatever the elements out of which it is compounded, *its most effective and most important ingredients will assuredly remain those borrowed from strict and untendentious psychoanalysis*' (italics added).

Ferenczi (1919, 1920, 1925) did take up the challenge. As already indicated, he hoped to resolve some of the problems of psychoanalysis proper and to find ways of shortening treatment. He opposed the analyst's 'passivity' by such 'activity' as: (1) preventing or prescribing certain forms of behaviour, such as omitting rituals in obsessional patients or exposing phobic patients to experiences that activate phobias; (2) arbitrarily setting a time limit for treatment; (3) the use of 'forced fantasies' to speed the exposure of hidden conflicts; and (4) assuming a definite role *vis-à-vis* the patient, a role that would somehow speed up the treatment by eliciting from their hiding-places the patient's neurotic transference reactions.

Ferenczi pointed out that Freud had already used some of these methods, such as setting a deadline for the end of treatment and asking phobic patients at some point in treatment to expose themselves to the phobic situation. Thus Ferenczi stated that he was merely further elaborating and experimenting with the principles that Freud had already introduced into psychoanalytic treatment.

Later Ferenczi and Rank (1925) published an up-to-date exposition and critical review of the psychoanalytic therapeutic process. They placed the patient's emotional experiences in analysis in the centre of their considerations as an attempt to correct the still prevailing excessive emphasis upon cognitive insight through genetic reconstructions. They felt that the re-experiencing of infantile conflicts in the transference neurosis was enough. It was not necessary to wait for the infantile memories to reappear; thus analysis could be considerably shortened. As a matter of fact they thought that, once the past conflicts were repeated in the transference and they were thoroughly understood, even without connecting them to the actual genetic events, the analyst could set the date for the termination of the analysis.

For a variety of reasons, Ferenczi's experiments were widely opposed. He himself soon acknowledged their failure (1925). The failure of these experiments, along with Freud's strong negative reaction to them, after his initial endorsement of the direction they took, inhibited the development of other forms of brief psychotherapy by psychoanalysts along psychoanalytic lines for some time. Another significant upsurge of interest in the demand for brief psychotherapy during and after the Second World War initiated renewed and more lasting efforts towards the further development of brief, analytically oriented therapeutic techniques.

This time it was Alexander and French (1946) of the Chicago Institute for Psychoanalysis who took up where Ferenczi's experiments had failed and where Ferenczi and Rank (1925) left off. These new experiments, begun in 1938, were much more systematically and 'publicly' conducted with the direct participation of nine other psychoanalysts (listed on the title page) and twelve others whose contribution is acknowledged in the Preface (Alexander and French, 1946). This is merely to note a significant advance in the attitude of a larger number of psychoanalysts than heretofore towards shortening of the psychoanalytic process (which has continued to become ever lengthier since the efforts of Ferenczi and Rank (1925) to find techniques for brief therapy, while not losing sight of the need for classical psychoanalysis) and towards the need to develop brief psychoanalytic psychotherapy. The book by Alexander and French (1946) and a decade later a very lucid exposition by Alexander (1956) review the relevant contributions of others and give a detailed theoretical and clinical discussion of their own.

Much earlier Alexander (1925) had already noted that Ferenczi and Rank (1925) justifiably attempted to correct the over-intellectualized procedure of psychoanalysis. They were critical of the stress on the interpretation of content, the focus on reconstructing, and the eliciting of infantile memories, and the relative neglect – even after Freud's recent papers on technique – of resistance and of transference. Alexander thought that the correction went too far into the other extreme, and he saw, perhaps not quite justly, the revival of the abreaction theory of cure at the core of Ferenczi's and Rank's new formulation of the therapeutic process in psychoanalysis.

Alexander and French (1946) re-emphasized the central importance of the emotional experience in analysis along with a re-emphasis of the

need for intellectual integration, i.e. the working through, which was relatively neglected, they felt, by Ferenczi and Rank. They stressed that the latter is ineffective without the former, and they placed the 'corrective emotional experience' upon the therapeutic axis of all forms of psychotherapy.

The corrective emotional experience results from the difference between the original parental response and the response of the analyst during the analysis. The patient, in his inevitable transference reactions, anticipates from the analyst the parental attitudes that shaped the adaptive-defensive repertoire of his behaviour. The fact that the analyst's responses are different from those of the parents provides the patient with an opportunity to correct his distortions. The emotional experience in the transference lends conviction to, and is the necessary underpinning of, insight. Having thus reached some stability, this insight elicits new, more up-to-date and reality-oriented solutions to old conflicts. This, so Alexander (1956) thought, was the key therapeutic factor in the standard procedure, implicit in Freud's formulations. He merely made this explicit and named it the 'corrective emotional experience'.

Alexander and French (1946) then, just like Ferenczi and Rank (1925) before them, resorted to the use of a variety of 'activities' in the hope of improving the standard procedure. Alexander (1956) later on described this as follows: 'the standard procedure can be improved by rendering the corrective influence of the transference situation more effective by giving increased attention to the interpersonal climate of the treatment situation.' How was this to be accomplished? Alexander thought that the intensity of the emotional re-experiencing of the past (i.e. transference) could be regulated to reach optimal intensity. This could be done by (to name only the most controversial among these technical suggestions): (1) changes in the frequency of the interviews; (2) temporary interruptions of the treatment (especially to deal with excessive dependency problems); and (3) replacing the spontaneous counter-transference attitudes of the analyst by assuming a deliberately planned stance, the opposite of the parental attitudes, to enhance the corrective emotional experiences.

Alexander and his co-workers (1946) demonstrated the effectiveness and the considerable value of their shortened therapies. Had they not claimed that their method 'improved' the standard procedure – which it did not - the heated controversy they aroused might have taken a very

different turn. Rather than examining the impact of these severely manipulative recommendations upon the therapeutic process, the argument shifted to the question of whether the new techniques constituted psychoanalysis or merely a form of psychotherapy.

The majority of psychoanalysts rejected the idea that Alexander's recommendation 'improved' the standard procedure. However, along with this rejection, unfortunately, they have also reaffirmed the sharp demarcation between psychoanalysis and psychoanalytic psychotherapy. This has further blocked serious attention by psychoanalysts to the development of a psychoanalytic psychotherapy that could be viewed on a continuum with psychoanalysis (Ornstein, 1970a; Ornstein and Ornstein, 1969).

Thus the second major systematic attempt in psychoanalysis to find shorter, effective therapeutic modalities failed along the same lines as the first one did. The attempts to introduce or to impose upon the analytic process certain arbitrary 'activities' that go beyond the interpretative interventions and manipulate the 'interpersonal climate' could not be absorbed into the mainstream of psychoanalysis.

The experiments of Alexander and French (1946) were followed by various other attempts to develop shorter forms of psychoanalytic psychotherapy. These need not be discussed in the present context since even those among them which were innovative merely emphasized one or the other aspect of the therapeutic process or technique already implicit or explicit in the standard technique. One such example relates to the manner in which transference phenomena are treated. Some workers regularly make use of transference interpretations even in brief forms of treatment while others consistently avoid them.

One specific contribution from the period just alluded to should be described because it has greater relevance for the main theme of this book. French (1958, 1970), in his attempt to develop a systematic and teachable method of approach to psychoanalytic clinical data, and to obtain guidelines for the clinician's interpretative activities, introduced the concept of 'focal conflict' and 'nuclear conflict'. For French the focal conflict is one that is preconscious, closest to the 'surface' at any one time, and explains most of the clinical material of a given therapeutic session. 'In a focal conflict, the impulses are condensed into a single conflict and then disbursed into the verbalization and productions of the patient' (Whitman and Stock, 1958). The schematic structure of a focal conflict is as follows: a 'disturbing motive' (an

impulse or a wish) is in conflict with a 'reactive motive' (a superego or ego response) creating the necessity for finding a 'solution' (an adaptive or defensive compromise). The focal conflicts are derivatives of deeper and earlier nuclear conflicts. These nuclear conflicts presumably originate during crucial developmental periods in early life. 'These remain mostly dormant, repressed or "solved", with one of them becoming activated (or having remained active) and continuously appearing to underlie behaviour in the form of focal conflicts – which can be identified as variations of the same theme' (Ornstein and Kalthoff, 1967).

French's therapeutic technique thus involves a consistent attempt to interpret the focal conflicts, allowing for the emergence of further derivatives of the pathogenic nuclear conflicts as therapy proceeds.

While there is a similarity in the use of the term 'focal' to its use in Balint's terminology, both the name and the theory and techniques it covers were independently arrived at by Balint. The similarities and differences of these two approaches will be evident from the chapters that follow.

In Chapter 10 we will discuss where focal psychotherapy fits in the developmental sequence just sketched.

CHAPTER 3

History of the Focal Therapy Workshop

For many years I had been interested in the possibilities of a therapy that would be much shorter in time than the classical psychoanalysis. It was clear to me that both patient and analyst would have to pay a considerable price for this brevity, or, in other words, both of them would have to take some risks. On the other hand, I thought that there were certain things about which one could not bargain. These were: (a) the results of this therapy must be comparable to those of an analytic treatment; and (b) they must be stable to about the same degree. The risks that I was willing to accept were: (a) many fewer people may be suitable for this sort of therapy than for analysis; (b) the chances of failure could be somewhat greater; and (c) I was prepared for the traditional techniques of psychoanalysis having to be modified to some extent.

A possibility offered itself to start research on these lines in January 1955. By that time Enid Balint and I had developed the method of training-cum-research seminars and tested it in two fields: for social workers who tried to help their clients with their marital problems; and in general medical practice for general practitioners who tried to understand and treat their patients' psychological problems. One might call these attempts short-term psychotherapy, or psychotherapy with limited aims.

Our first research team was recruited entirely from the staff of the Tavistock Clinic. It was somewhat heterogeneous, including two consultants, two registrars, two psychologists, one psychiatric social worker, and a psychoanalyst who was an honorary associate of the Clinic. On the other hand, three of the members of the team, although sympathetic to psychoanalysis, were not properly trained; the other five were either psychoanalysts or were in training. As most of us had no practical experience in the field that we were studying, the only thing that we could do was to produce fairly firm views based solely

This chapter was completed by Enid Balint after Michael Balint's death.

on preconceived ideas. As might be expected, our experience gradually proved that the majority of our preconceived ideas were simply false. This in turn led to considerable disappointment and to irregular attendance at our research meetings. Gradually it had to be accepted that this phase of our research had to be given up; this happened at Easter 1956.

In November of that year we started again with a team consisting entirely of analytically trained members, partly from the staff of the Tavistock Clinic and partly from the Cassel Hospital. The smaller half – the core – of the team consisted of four who survived the first phase: Enid Balint, John Boreham, David Malan, and myself. The newcomers were: Joseph Jacobs, a most talented therapist from the Tavistock Clinic, Tom and Agnes Main, Malcolm Pines, Julius Rowley, and Eric Rayner, all from the Cassel Hospital. It was this team that worked out the idea and the methodology of what later was called focal therapy.

For various reasons, the workshop was wound up during the summer of 1961 after a life of almost five years. Although the reasons for its termination were many and complicated, one that is perhaps worth mentioning was that most of the members, being fairly newly qualified analysts, were perhaps too absorbed with traditional analytic thinking to be able to proceed with the tasks that lay ahead. It was very difficult indeed to realize that the new techniques and way of thinking did not endanger basic psychoanalytic theory and practice: that they were supplementary and not antagonistic to each other.

CHAPTER 4

General Structure of Focal Therapy: Use of the Forms

Some of the problems facing the psychoanalyst when doing brief psychotherapy have already been mentioned. The structure of our work aimed to minimize these difficulties in so far as each member of the group, including the leader, Michael Balint, reported on his own work as well as exploring and criticizing the work of the others. We shared our experiences and jointly examined our clinical hypotheses in a setting where therapeutic success was not the only aim. Failure and partial failure were accepted. We all had a common psychoanalytical background and we were all active members of the group.

Two members of the workshop were also psychologists and they thus played an additional role, doing psychological tests and reporting on them as well as doing and reporting on therapeutic interviews. They were full working members of the group. This structure was not without difficulty because of the inevitable overlap between psychological and psychiatric reports. However, there were obvious differences in so far as in the test situation the set of stimuli provided by the psychologist is systematic and prearranged, whereas the stimuli provided by the psychotherapist are always improvised and hence never systematic.

The Focal Therapy Workshop met once a week for a period of two hours. Forms, discussed in detail below, had been filled in by whoever had seen the patient, and circulated to the members of the workshop before the meeting. Discussion was on the basis that everyone present had read the forms. The discussions were usually taken down verbatim by a secretary, and the reports were circulated to the members of the group. The therapist elaborated on what he had written on the form, but there was no other, formal, report on the session. Right from the beginning of the work it had been decided that, although each member of the group would be left to conduct his interviews in whatever way he

This chapter was written by Enid Balint after Michael Balint's death.

wished, and to report on them freely during the meetings, some structure was needed so that relevant and useful observations and communications about interviews could take place. We wished to report significant and not irrelevant transactions, and the forms and their headings that emerged during our work were the structure we developed to enable such data to be noted and compared. The forms changed as our ideas about what were significant data developed. As has been pointed out in the Introduction, our intention was that we should be as little tempted as possible to become involved in the psychopathology of the patient as an individual on his own (i.e. in one-person psychology), but instead concentrate more on the interaction between the patient and the therapist, and on the processes and techniques that developed as a result. Our interest was to study object-relationships not merely in terms of fantasies about, and reconstructions of, the past, but object-relationships that could be observed in the current life of the patient and in the interview situation. From these observations we hoped to be able to study techniques that were appropriate, i.e. what kinds of verbal and non-verbal intervention were appropriate in terms of what we came to call 'the focal aim'.

Michael Balint and I had already developed, in our work with the Family Discussion Bureau, a form on which to structure our thinking. We soon found this form inadequate and started to develop forms in which the relevant observations and transactions in our particular work could be communicated. In the next chapter, which is the major part of this book, the use of these forms is demonstrated. It is my aim here merely to summarize some of the reasons why the particular headings were chosen.

Broadly the aims of the forms were as follows:

1. INITIAL INTERVIEW FORM

The headings in this form demonstrate the data we saw as significant, so that we as a group would be able to discuss the patient and a decision could be reached in due course – not at this diagnostic, initial interview stage – about whether the patient could be helped (a) in a shorter time than that taken by a classical psychoanalysis, and (b) with a clear idea of what aspect of the patient's illness should be treated. We did not think that we would be able to treat the patient if we made only a general vague diagnosis in psychiatric, or even in object-relationship,

terms. We felt that we had to define our aims clearly, and also to estimate the time we thought it would take to achieve them. The headings in the initial interview form set out below were chosen to act as a basis for our thinking.

A. Referral

B. 1. Appearance and manner of patient
   2. Complaints
   3. What seems to bring the patient now

C. Factual material

D. 1. Patient's conception of himself
   2. Patient's conception of other people

E. Doctor–patient relationship
   1. How doctor treated patient
   2. How patient treated doctor

F. Salient features in the interview (or, sometimes, 'Important moments in the interview')

G. 1. Ways in which disturbance is shown in patient's life
   2. Interpretation of above in dynamic terms
   3. (a) Suitability for focal therapy, with reasons
      (b) Points against focal therapy
   4. Immediate aims

The aim of these headings was to enable the workshop not only to discuss what could be done in a brief therapy, but what the particular therapist who offered to take on the case after discussion with his colleagues wanted, and felt able, to do.

It will be seen in Chapter 5 that as Michael Balint had not, in this case, felt able to formulate his impressions before he had seen the patient a second time, he did not complete the entry G in accordance with the above headings. Instead, he noted: 'G. Summary to be completed after a second interview.'

2. SESSION REPORTS

Here a new factor was brought in. The aim was not only to discuss the aim of the therapy and to report relevant data about the doctor–patient relationship but also to record the therapeutic process that had begun between this particular doctor and this particular patient. The headings

demonstrate our changing ideas about the importance of these different factors. Thus it will be found, in Chapter 5, that here too the headings varied slightly from time to time although the general structure and way of thinking remained the same. The standard headings for sessional reports were as follows:

A. Initial expectations

B. Atmosphere in interview, with changes if any
   1. Patient's contribution
   2. Therapist's contribution

C.&D. Main trends and therapeutic interventions given

E. Therapeutic interventions thought of but not given

F. Therapist's focal aims in interview

G. Outcome of the interview

H. Afterthoughts.

The therapist, in describing his work under these headings, demonstrated the therapeutic process to the working group, and any inconsistencies in his work or in his thinking could be seen, perhaps more clearly than if a verbatim report had been available to the workshop. It was easier for the workshop to see what was going on, i.e. to realize the effect of one intervention or interpretation on the subsequent session, than it was for the therapist himself. But even for the therapist, the discipline of having to think about what he had done and why he had done it, and what had been its effect, and whether he had adhered to his original intention of keeping to a particular focus or whether he had not, and if not why not, and the outcome, gave very little opportunity for dishonest thinking or reporting.

The headings for the report by the psychologist on his projective tests have much in common with the headings on the initial interview and session reports. The same factors were noted, but in addition the character structure and psychopathology of the patient were also studied, and were a useful control or comparison. The diagnostic summary was couched in more traditional psychiatric terms by the psychologist, as were, on the whole, his pointers for and against focal therapy. These more traditional ways of thinking, expressed as they were by a psychoanalyst who was also a psychologist and a full working member of the workshop, were an indispensable part of the structure of the workshop. If, as is noted in Chapter 9, there was too much

inconsistency between the two reports, i.e. between the patient's behaviour in the psychiatric interview situation and in the psychologist's interview situation, this was thought to be a pointer against focal therapy.

The headings for the follow-up reports followed the same pattern as the headings for the session reports.

CHAPTER 5

History of the Treatment, Follow-up, and Comments

This chapter is perhaps the most important one of the whole book. It contains the complete history of Mr Baker's treatment from the initial interview till Session 27, the last treatment session, and it includes a detailed follow-up of the therapeutic results extending over more than six years. All the other chapters centre upon this one, either preparing the ground for its understanding or drawing conclusions from the observations reported in it.

The whole history is told in the form of session reports dictated by the therapist (MB) immediately after each session. We discussed in the Introduction the advantages and drawbacks of this sort of recording and reporting. Most session reports are followed by comments written by the two of us, calling attention to this or that feature of the preceding session or discussing the problems as they were encountered during the treatment. To help the reader find his way through the events of the treatment a chronology of these is given in the time-table on p. 21.

INITIAL INTERVIEW FORM

NAME OF INTERVIEWER Michael Balint
DATE OF CONSULTATION 8 November 1960
NAME OF PATIENT Mr Keith Baker
AGE 43 OCCUPATION Company director

A. REFERRAL

Urgent trunk call [i.e. long-distance call] from a very clever GP who had referred a number of patients to me, all excellent referrals. He asked me to see one of his patients, a very ill man whom a psychiatrist wanted to hospitalize. I have known the psychiatrist for quite some time. We are on a good, friendly, basis. As he came to a rather doubtful

prognosis, he insisted on a Rorschach, which apparently was in complete agreement with his findings. It was at that point that the GP rang me up. Of course, I asked for a letter from the psychiatrist and for the Rorschach report which the GP promised and which in fact arrived next morning. In the former, the psychiatrist expressed great relief that someone would share the burden of responsibility.

B. 1. APPEARANCE AND MANNER OF PATIENT

Properly but not meticulously dressed man, quiet but somewhat punctilious. Obviously under strain but controlling it well. His story was presented systematically but not absolutely rigidly.

2. COMPLAINTS

Increasing preoccupation with his wife's feelings towards a young man who seriously courted her before their marriage about twenty years ago and with whom she had had no further contact whatsoever.

3. WHAT SEEMS TO BRING PATIENT NOW

Patient had one serious breakdown about six years ago that was very bad for a few months and gradually tailed off; it lasted altogether for about eighteen months. A few weeks ago something similar started off but it was much less severe. This led to the psychiatric investigation and eventually to his referral.

C. FACTUAL MATERIAL

Patient comes from an old-established east-coast Church of England family, several generations of printers and stationers. Went to school until 16, took school certificate, and since then has been working in the family firm. Recently father retired, selling out enough of his shares to the three brothers who by that acquired controlling interest among themselves. Father is now chairman of the company while the three brothers are joint managing directors. They work excellently together, the eldest brother, about seven years older, is steady and sensible, an excellent support, whereas the patient is the driving force and the one who has ideas. The third brother is three to four years younger than the patient and is the administrator.

During the war the patient was in Cyprus and met his present wife, a Turkish woman, there. They fell in love with each other at first sight. He was then about 24 years of age. He had had several women before

TIME-TABLE OF MR BAKER'S TREATMENT

Age when treatment started	43
Age when treatment ended	44–45
Age at 1970	53

		Date	*Interval*
First consultation	Session 1	8 November 1960	
End of diagnostic period	Session 2	14 November 1960	6 days
Start of treatment proper	Session 3	24 February 1961	15 weeks
Weekly sessions until and including	Session 13	12 May 1961	6 weeks
Tentative tailing-off of treatment	Session 14	23 June 1961	7 weeks
	Session 15	11 August 1961	7 days
	Session 16	18 August 1961	
Probable date of winding up of Focal Therapy Workshop, treatment continued without being discussed by team		August 1961	7 weeks
Restart of treatment	Session 17	10 October 1961	
Twice-weekly sessions until and including	Session 22	27 October 1961	
Weekly sessions until and including	Session 26	24 November 1961	
Last treatment session	Session 27	11 February 1962	
First follow-up by letter 1		30 April 1962	(approx.) 6 months
First follow-up session	Session 28	2 August 1962	8 months
Follow-up by letter 2		5 April 1963	2 years
Follow-up by letter 3		14 April 1965	4 years, 3 months
Second follow-up session	Session 29	25 November 1966	
Therapist's letter to general practitioner		1 March 1968	
General practitioner's reply		4 March 1968	
First psychological test		24 October 1960	
First test rewritten		14 April 1961	
Re-test		20 July 1961	

then, mainly prostitutes, nothing serious. She was the first real woman in his life. Great resistance by her family, especially father, because of racial and religious reasons. Gradually developed heavy petting but no intercourse, although especially on one occasion she almost offered herself to him. That was just before he was posted to India.

There he was just behind the Burma front, working hard and keeping up a frequent correspondence with his fiancée-to-be. He contracted dysentery and was hospitalized. Did not get any letters, was very agitated, cabled, and then, at long last, a letter arrived informing him that the girl had met a young officer, and they had fallen for each other. She was somewhat uncertain which of the two men she should choose. He wrote her letters imploring her to stay by him and eventually she wrote that she had made up her mind and had broken off with the other man, who departed. The patient eventually came back to Cyprus. They were very happy together but still did not get engaged. He was then posted to Italy where he remained until the end of the war. Then he returned to Cyprus and married his wife. He believes in God, but not in rites.

The marriage was very happy right from the start. They have three children, according to him all well adjusted.

After demobilization he returned to the family business and it was mainly as a result of his influence that it developed to its present really excellent standard. This is accepted by everyone.

D. 1. PATIENT'S CONCEPTION OF HIMSELF

A reliable, sensible and very loving man, a man with imagination and drive. Very troubled by his worries and he feels he needs some help to sort them out. He is quite certain that he will be all right if this can be done.

2. PATIENT'S CONCEPTION OF OTHER PEOPLE

Father – somewhat old-fashioned and rigid but one can get on with him. *Mother* – never mentioned. *Eldest brother* – steady, down-to-earth, most reliable. They complement each other admirably. *Younger brother* – hard worker, no trouble. *Wife* – charming, warm, and most loving. Could not imagine anybody better or better suited to him, but he cannot sort out how she could have felt for another man something similar to what she feels and has felt towards him. *Children* – healthy, well adapted, a source of real pleasure and affection.

E. DOCTOR–PATIENT RELATIONSHIP

1. *How patient treated doctor* A very great need to talk to someone who might possibly help him to solve his painful problem, then a hope developing that he might possibly have found the right man, and lastly, a highly appealing, almost childish, confidence that this has happened and now we can get on with the job.
2. *How doctor treated patient* Tried to be very cautious throughout,[1] but could not help responding positively to his apparently sincere and warm appeal. Of course, I was aware of its latent homosexual, paranoid nature; still, the appeal was there and was very strong.

F. SALIENT FEATURES OF THE INTERVIEW

Of course, there was the usual paranoid atmosphere of inexorability. He could not understand how his wife could have affectionate feelings for another man, although he could understand that she might have been sexually stirred up; so he had to go on and on and on grinding her down until he extracted from her the minutest detail about what happened between the two young people; when and how they kissed, which part of her body was touched, what she felt in response, and so on. The wife's response was also the usual – first trying to minimize it, then to mislead her husband with subterfuge, then in despair denying the whole lot, and finally, having been completely defeated, relating the details that her husband asked for, only to be asked for more which she did not have, and so on. All this took several years and during this time she got involved in hopeless contradictions that had all to be sorted out, admitted, and recanted.

After listening to this dreary and very painful story, I brushed it aside, not brusquely but in a friendly manner, and said that apparently it was not the details that were important but what he felt about them, and that apparently he needed somebody to act as a sounding-board in order that his fleeting ideas, fantasies, and emotions should be reflected upon him so that instead of vanishing into limbo they should make some impression on him.[2] This must have touched off something rather deep in him because he returned to it on several occasions during the

[1] i.e. not too much on his side, nor too critical of his behaviour.

[2] This is a sample of the focal therapy interview technique in the diagnostic period. We deliberately give interpretations or expose the patient to some situation, causing an increase of tension in him in order to see whether he is able to continue working and using this new experience in a constructive way.

interview. Moreover, his gratitude for this little piece of understanding was really moving.

As time was passing, I proposed that we should ask his wife to come up (she was waiting downstairs and wanted to talk to me after the interview) to which he gladly agreed, and I had a quarter of an hour with the two of them. She is a good-looking, very dark, 40-year-old Turkish woman; nice, affectionate, and warm to her difficult husband, but somewhat at a loss how to express it. Nevertheless, there was no question but that the two people belonged to one another. Her story tallied in every respect with her husband's. It was remarkable that she admitted freely the many contradictions in her various versions of the courtship with the other man and was not embarrassed by it in the slightest. I think this is a reliable sign with regard both to their relationship and also perhaps to the severity of her husband's illness.

At the end Mr Baker asked to see me again as soon as possible, so I agreed to see him on Monday, 14 November.

G. SUMMARY

To be completed after the second interview.

SESSION 2 14 November 1960

Length of interval since last session: 6 days

A. INITIAL EXPECTATIONS

Some easing of the tension and increase of his friendly, somewhat homosexual affection towards me.

B. ATMOSPHERE IN INTERVIEW WITH CHANGES IF ANY

1. *Patient's contribution* Actually, much more than that happened. He was most appreciative and thanking me warmly told me that after the last interview he and his wife really understood each other. They saw the whole situation in a different light. He went home and for the first time for some weeks slept without any phenobarbitone, had a very restful sleep, and woke up feeling much better the next morning. In fact, he is so well that he is contemplating going back to work gradually, starting this week.

2. *Therapist's contribution* I remained cautious but again could not be

completely unresponsive to this warm overture, and tried, especially in the second part of the interview, to start doing some work. His responses were somewhat equivocal.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

First I had to ask him a few factual details that I had had no time to inquire about in the first interview. I learned that ever since his marriage he had pondered on and off about how it could have happened that his wife felt any sort of emotion towards the other man, but this did not make him ill. In the mid-fifties he had a proper breakdown, could not get up out of bed, felt very tired, slept a lot, and this worry came down on him in real force. For about 3 to 4 weeks he only wanted to be left alone with his wife in complete peace. Then he gradually got better, started to work part-time, and in 4 to 5 months he went back to work. When I asked him what other events took place about the same time, I learned that he had moved into the new house that he had built for his wife and family a few months before the breakdown, and his father-in-law, whom he was very fond of, had died at about the same time, possibly somewhat later.

He felt all right until spring 1959 when he went for an early holiday and the same sort of depression came over him, with the same kind of preoccupation as previously. This has been on his mind ever since, with some exacerbations (during one of which he mentioned the whole story to his eldest brother for the first time), but he went on working until early October, when he broke down, and this led to his referral to the first psychiatrist. In answer to my question, he added that it was in the spring of 1959 that he and his two brothers had eventually bought their majority interest in the business from their father.

I asked him one more question: who were the people who knew about his worry. Apart from his wife, there are his two brothers, a very intimate friend whom he has known since they were eight years old, and his doctors; nobody else.

He talked about his future plans. He would like to go back to the office and works for say two half-days this week, and, if he can take it, gradually for longer and longer until he is fully back at work. He would like to spend Christmas at home as he and his wife are the only fixed point in his wife's whole family. All brothers and sisters of his wife, except one, emigrated from Cyprus and are all over the world, most of

them still unsettled. Two of his brother-in-law's children are at present living with him. He added smilingly that he and his father-in-law were very, very fond of each other, although they could not speak the same language – his father-in-law speaks only Turkish, but he used to say that he wished that all his sons-in-law were Englishmen.

Then he returned to his preoccupation: how could it happen that his wife, who was really in love with him, could mistake her sexual excitement for an affectionate love for this other man. First, I tried to get associations about the possibility that his wife was disappointed in him because he did not press her harder before leaving for India. Although he admitted this in principle, he marshalled so many arguments against it – an officer has to apply for permission to marry to GHQ, this takes about six months, any such application is usually followed by a posting, etc. – that by the end he had convinced himself that what he did was the right thing. He added that possibly it was just the fact that he was so considerate with his wife that won her over to him.

He then told me that now that he knows all the facts and that at long last he and his wife understand each other, he thinks the only thing he needs is some time to work himself through it and things will be less difficult. In the past he couldn't tell his wife what he really wanted, and his wife couldn't understand his demands, and it was in this way that the two got involved in so many misunderstandings and contradictions. Now all this has been cleared up and he is quite confident about the future. The next moment he contradicted this by getting back to his paranoid ruminations, asking me how it was possible that his wife could think that she was really in love with the other man. I tried again to switch the associations away from the absent partner back to the present one (himself), this time by pointing out that for several years he had been able to bear this problem without much trouble, but something must have happened to him about six years and again about eighteen months ago that brought things to a head; perhaps if we could find out what these things meant to him he might be in a better position to prevent another breakdown. He did not like this at all, but instead of showing it he went back to talk about his paranoid preoccupation. I interpreted this to him point-blank, showing him that we were talking at cross purposes, he about one thing – how his wife could have done certain things, and I about another – what events in him had contributed to the two breakdowns. He accepted this fact, did

not do anything to remedy it, but remarkably this did not at all change his friendly relationship with me.

We had to stop here because of time, so we discussed future plans. His idea was to have a kind of symptomatic treatment, what he called working himself through what he had learned recently from his wife, using me only as a sounding-board, that is, for a maximum of 5 or 6 sessions. I contrasted this with my idea of finding out what had happened in him that led to the two breakdowns, and assessed the time needed for this as about 10 to 20 sessions. He asked me to write to his doctor, promised to discuss it with his wife and then with his doctor, and then to let me know. We parted good friends; he shook my hand very warmly and thanked me profusely for what I had done for him.

E. THERAPEUTIC INTERVENTIONS THOUGHT OF, BUT NOT GIVEN

These were: his latent homosexual jealousy of the other man on the one hand, and his feeling of inferiority towards him on the other; nor did I try to bring out his possible guilt feelings about having a beautiful new house, surviving his father-in-law, that is, triumphing over him, and conquering his father by buying his interest in the business. And, lastly, I have not pointed out his need to be on very amicable terms with every man who means anything in his life and the importance of it for the developing transference relationship.

F. FOCAL AIMS

In the first part of the interview I thought I had found it in the guilt feelings caused by his triumph over his homosexual rivals: the other officer in Cyprus; his father-in-law; his own father; but it is quite possible that this will prove to be too ambitious. In this case a secondary aim might be to enable him in the transference to find a man with whom he can share his wife (symbolically).

G. OUTCOME

Must be described as a draw. He could not move me but I could not move him either. This, however, is not therapeutic at all.

H. SUMMARY

Diagnosis unquestionable — a jealousy paranoia with all the classical features of obsessional character, latent homosexuality, and so on.

The slow but uninfluencable development belongs to this same picture. The building-up of a proper paranoid system is the work of a life-time.

Possible therapy:

(a) Analysis. He doesn't want it, is afraid of it, and it is questionable whether he would be able to afford it, either in time or in money. A further question, how much can analysis do to change a jealousy paranoia radically?

(b) Focal therapy – focus selected by me. (Guilt feelings caused by the triumph over homosexual rival.) Negative response by the patient.

(c) Focal (symptomatic) therapy – focus selected by the patient. (Sharing his wife with a man, that is the therapist in the transference.) Might be used as an entry but possibly might be accepted as the whole therapy.

Points in favour:

(a) Very good ego-structure, excellent work-record, good business success. Very good and intimate loving relationship with his wife, satisfactory sexual life, possibility of harmonious understanding between the two.

(b) Paranoid ideas strictly limited, no spreading over to any other areas.

Points against:

(a) Long duration, minimum 20 years, progressive course.

(b) Positive reaction as long as I keep out of his paranoid circle, complete brickwalling as soon as I try to relate to it.

Decision:

It was decided that after he has discussed the matter with his wife and with his doctor he would ring me up and let me know what the decision was.

COMMENTS ON SESSION 2

In Session 2 the therapist felt safe enough to try a second interpretation, which expressed in explicit form that it would not be enough if the patient talked only about his wife, i.e. the absent partner, and

what she might or might not have felt in Cyprus when she hesitated between the two men. But it will be necessary also to find out what was happening in Mr Baker that caused the breakdown about six years ago, then again eighteen months ago, and at the present time.

Although the patient accepted this proposition in principle, he was not able to collaborate on these terms. This might be one of the causes that led him to stay away from treatment for fifteen weeks and return only under the impact of a serious deterioration in his condition. Of course, there might have been other causes for this delay. To mention only one – as we know, a number of patients need this sort of time for a decision to start therapy.

Perhaps a few words about the two foci chosen. The choice reflects the therapist's ideas about the possible dynamic etiology of the illness. He considered it a fairly classical instance of a jealousy paranoia, with the three classical sources, anal erotism, homosexuality, and rigid obsessional tendencies. The therapist thought that in this case the most important factor was the patient's homosexuality, which could not tolerate that there were men who would not love him. Expressed as distorted by the patient's projection this would run: men would compete with him for his woman's love and become his rivals, i.e. his enemies instead of loving him. The fact that he could not accept was that in the case of his wife he defeated his rival, which was the final proof that his rival will forever remain his enemy and could never love him. It was in this sense that the first focal aim was described as the more ambitious one, to enable him to accept his ultimate victory, that is, the fact that he will never be able to enjoy the love of his rival.

The second focal aim is described as 'symptomatic' because, by sharing his wife symbolically, he dispenses with the victory, nobody is the conqueror, so perhaps the men need not hate each other. There always remains a possibility of harmonious coexistence. This is, of course, based on by-passing the need for reality-testing. Expressed in homosexual terms, the ambitious focal aim would mean that he would be able to free himself from the homosexual attachment to the extent that he could beat his rival. The second aim would mean a compromise: the importance of the rival is reduced, but the patient must give him a symbolic share of his wife in order to retain his rival's affection.

SESSION 3 24 February 1961
Length of interval since last session: 15 weeks

A. INITIAL EXPECTATIONS

His GP rang me up yesterday asking for an urgent consultation as Mr Baker had been much worse recently. In the meanwhile the GP has kept a watching brief on him but has not done very much. It was left to me to decide whether to start treatment with him or not.

I expected a serious deterioration of the paranoid condition and a near breakdown situation.

B. ATMOSPHERE IN INTERVIEW WITH CHANGES IF ANY

1. *Patient's contribution* He was rather haggard, looked ill, and, though composed, was depressed. Unquestionably no breakdown yet. He has been working ever since my last interview. He was honestly worried about his present state and asked for help.
2. *Therapist's contribution* Sympathetic and trying to help him to get nearer to his complicated reaction formation against his latent homosexuality.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. Everything went more or less all right with him until a few weeks ago when his wife went to the GP. When Mr Baker asked her why she did so, she told him that she simply could not bear any more and had to unburden herself. A further long discussion took place in which his wife admitted that a lot of the stories that she had told him under his persistent pressure were inventions in order to calm him down, and what really happened between her and the other officer in Cyprus was what she had told him at first, both in her letters and when they met after his return from India.

This gave him a very bad jolt for two reasons. First, he realized how unbearable his constant nagging must have been to his wife, and, second, it again shook his confidence in his wife's veracity. In addition, there have been some considerable troubles in the works, and there have been all sorts of mechanical breakdowns with which he has had to deal in the last fortnight. This has caused a great strain on him. I brushed to one side all the external events and interpreted his cruelty

and ruthlessness to his wife. He had obviously felt very badly hurt by her and ruthlessly took revenge for it.

2. This he accepted without any difficulty and went on describing how badly he was hurt; he simply cannot forget it or escape from it. Though he realizes all this hurts his wife, he simply cannot stop himself because he feels that she let him down very badly by her lack of understanding of what all this meant to him. Here I intervened and said that the hurt cannot be undone or escaped from, the only thing that can be done is to accept the fact and live with it; but this apparently is what he cannot do, and here I repeated that he must have his revenge.

3. He then realized that this hurt must have a special significance for him as, of course, he has been hurt several times in his life and could accept and live with other hurts but not with this one. I accepted this clarification and added that this means that the hurt started well before Farah (his wife) appeared on the scene; it must have had a long pre-history.

4. He readily agreed and from there we went on talking about his feeling inferior to any other man; everybody else is a better, bigger, or more attractive man, which means that he will be worsted by them. This was substantiated by various details about the officer (the other man who flirted with his wife-to-be in his absence in India). Every detail that was reported about this man was interpreted by Mr Baker as proof that the other man was better than he. I then picked it up and showed him that the same details admitted just the opposite interpretation, namely that Mr Baker was superior to the other man. He was greatly surprised but could not escape its impact.

5. From there we went back to his experiences with various women before his going to Cyprus. They amounted only to prostitutes and one local girl, 'easy meat'. There were other girls as well, but he always ran away when they became interested in him and wanted some love-making. He repeated two incidents in detail: one when he was twenty and a girl with whom he had been going out for some time got hysterical because he did not proceed; and another, during the early part of the war, when a girl from whom he ran away one night and returned to the next night was not interested any more. He finished by realizing that what he was really afraid of was making these girls pregnant.

6. He had to stop here as his time had been overrun, and he asked for treatment. I offered to see him once a week several times to decide

whether we could possibly do anything in this way, or whether he would need analysis. He agreed, but asked whether he should go on or refrain from churning over these incidents with his wife. I told him I could give him no instructions; he must do what he has got to do, but the only thing I would like would be that he should report it truthfully during the next session. We agreed to meet the following Friday.

E. THERAPEUTIC INTERVENTIONS THOUGHT OF BUT NOT GIVEN

I am getting nearer to his jealousy of the man, but I thought I would not interpret it for the moment. The other possible interpretation would have been his great confidence and trust in me, which also has a very strong sublimated homosexual tinge. I intend to do it soon.

F. FOCAL AIMS

After the session, I read what I had said in Session 2 about focal aims. I think it should be repeated exactly in the same words here.

G. OUTCOME

Uncertain but not hopeless. He certainly moved a little and we shall see what happens.

COMMENTS ON SESSION 3

An interval of 15 weeks followed Session 2, possibly filled with painful vacillations for the patient. On the one hand, the therapy proposed meant to him that he would gradually have to give up his homosexual interest in his rival, change it into heterosexual love, and transfer it to his wife. He must have felt that this was an enormous demand on him, and his first response was to try to see whether he could go on unchanged. When this did not succeed, and his state deteriorated, he was referred for therapy by his general practitioner.

The events in the treatment described in Section C&D 1, 2, and 3 could have been taken as a basis for an alternative focus. In fact, this could have been justified because the problem of cruelty (not of hatred) has turned up in subsequent sessions time and time again. This means that if cruelty had been chosen as a focal area, the therapist would not have had any difficulties in leading his patient's association in that

direction. The fact is that the therapist did not change his focus, and it is even questionable whether he considered such a possibility or need. Now, when commenting on it, we can try to reconstruct the possible reasons for not changing the focus. On the whole, there are two groups of considerations. One is that cruelty is a somewhat general notion, which means that the focal area would have been too wide and ill defined. The other consideration is a sort of rule of thumb: one should not abandon a focus only because another attractive idea emerges; for changing the focus, one must have some positive evidence that the original focus or foci were badly chosen and probably will not work. No such evidence was available to the therapist, nor did it emerge later.

It was in this session that the topic of suffering, of causing pain, first emerged clearly, and could be worked with. It is difficult to say who mentioned it in so many words for the first time, patient or therapist. What is important is that it emerged in joint work. Right from the start it appeared in this double form, namely, Mr Baker had to torment his wife because he was so badly hurt by her and very soon (see e.g. Sessions 12-14 and 17-18) the third aspect will emerge, namely, tormenting his wife was a torment for him too.

Although the intensity of this oscillated enormously and was eventually dealt with, as will be shown in the follow-up, its configuration remains the same.

In this session, in spite of what happened in Session 2, the therapist went on with his interpretative work, cautiously, but not overcautiously. He did not stop when he observed that his interpretations caused considerable strain to Mr Baker. It was the therapist who offered the word 'cruelty' instead of 'nagging' and stuck to it. In this session, Mr Baker could accept the interpretation offered and an interesting piece of his psychopathology became clear: he was hurt by women because they rejected him, and hurt by men because they were so much better and superior.

SESSION 4 3 March 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Expected some improvement and the deepening of our sublimated homosexual friendship, but I got still more.

B. ATMOSPHERE IN INTERVIEW WITH CHANGES IF ANY

1. *Patient's contribution* Very honest, warm, and sincerely trying to get on with his problem. Of course, there was the friendly and companionable atmosphere characteristic of a passive homosexual relationship.
2. *Therapist's contribution* Accepting this and trying to use it to further the work.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. Things are considerably better. There was no strain during the whole week except on one occasion when he had had a very crowded social day. Following that, he had another discussion with Farah which clarified certain points to his satisfaction. They agreed that her feelings were more sexual than sentimental and he found it acceptable that in his absence another man could have stimulated a young girl in this way (she was a young girl in her early twenties).
2. He went on that the reason that he cannot accept the facts and have done with them must go back to his experiences in childhood and adolescence, especially in relation to his father. His father is a man of very bad temper who constantly humiliates practically every member of his family – the patient, his sister, his mother, and so on. Even now when his father comes into the office and is in a 'difficult' mood, Mr Baker feels uncertain and has butterflies in his stomach.

A very early memory, perhaps the earliest, is that he is lying in bed during the night, a small gaslight is on, and father comes into the room with a red-hot poker in his hand, his false teeth sticking out, looking exactly like a frightening monster.
3. Without any interruption he recalled that when he went to boarding school at the age of 12½ or so, another boy, a prefect, started to fool about with him after lights out. A master switched the lights on, surprised them, and they were caught red-handed, the other boy sitting on his bed and masturbating him. There was a great to-do about it. He was severely ticked off by the housemaster and the other boy caned.

Then at about 15 he had a very warm friendship with another boy, just a bit older than he, and for some reason or other they quarrelled. The other boy was upset and came to make it up with him after lights out; he was sitting on his bed, but nothing else happened. They were again caught, by another master, but this time nothing happened

immediately. When he returned home after term ended, however, his father confronted him with a letter from the housemaster in which this incident was described and the parent was asked to deal with it. He was so frightened he ran to his mother, saying that he could not stand 'that man', meaning his father. Still he had to go back to him and father 'whipped him' with his tongue so that he felt terribly small.

4. During the whole holiday father never missed an opportunity to wipe the floor with him, alluding to this objectionable behaviour at school.

5. After some hesitation he then told me a further incident. They lived in a village where according to father no village boy was good enough company for his children, so he had no friends except, remarkably, a Jewish boy who has remained his best friend until now. Because of his isolation he was thrown back onto going round the printing works, and he became friendly with a man who worked as an engineer for his father. One day, when he was about eight, he arrived at the engineering shop with his hands in his trouser pockets. The man asked him what he was doing with his hands and undid his flies and masturbated him there and then. This was the first time that Mr Baker experienced orgasm and he thinks that this started his period of masturbation, which lasted up to about the age of 20, during which time his friendship with the engineer was on and off whenever he returned from school.

6. It was here that I intervened, pointing out that the experiences in his childhood and adolescence created in him a feeling that he was not a proper man, that other men were superior to him, and that he had to lose whenever he competed against anyone else, like father or the other officer. I linked the fact that he was able to tell me all this rather embarrassing material with the other fact that at the last session I interpreted his incessant questioning as cruelty towards his wife. Now *he* had to tell me all these embarrassing details. He accepted the connection, and then some indecisive work followed in which his feeling of inferiority towards other men was linked by him with his inability to accept any version of the incident between his wife and the man as final. He especially emphasized that he is less concerned with the fact that his wife was sexually stimulated than with the disquieting possibility that she might have loved the other man.

E. THERAPEUTIC INTERVENTIONS THOUGHT OF BUT NOT GIVEN

Interpreting the cruelty to his wife as an expression of his latent homosexual jealousy, that is, his love for his rival.

F. FOCAL AIM

Unchanged. I am getting more confident that it will be possible for the more ambitious version, that is, his love for the father and any strong man, to be interpreted in so many words, as well as his inability to win in competition against them.

G. OUTCOME

I think fairly good progress has been made.

SESSION 5 10 March 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

After the events of the last session I expected further material about his homosexuality and hoped to be able to bring it into the transference.

B. ATMOSPHERE IN INTERVIEW WITH CHANGES IF ANY

1. *Patient's contribution* Much relieved but still sincerely concerned, working fairly hard.
2. *Therapist's contribution* Accepting this fact and helping patient to get on with the job.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. First reported considerable improvement. The whole week was all right except on one occasion when he had a kind of set-back. This was on Tuesday afternoon when, as is the rule with him when he anticipates a social engagement, he was tense and jittery. The social event was a party with his cousin, in whose company Mr Baker always feels socially inferior.

He came home for lunch as usual on Tuesday and again started questioning Farah; this led to floods of tears from him. When I asked

him what he was so desperate about, his answer was that it was because he was so utterly lonely. I interpreted here that apparently he cannot be confident that he has ever had, or will ever have, a loving wife.

2. This was accepted and related immediately to his relationship with father. Mr Baker repeated that his father has always 'wiped the floor' with him and until recently he was never sure whether father in his rage would not upset all the working arrangements and, for instance, leave the whole business to his daughter, in order to spite his three sons. Although this issue is now settled by a legal agreement, Mr Baker still does not feel quite safe. I interpreted that apparently he is not only dominated by father, but in some way or other cannot rebel against him, expects and perhaps desires to be dominated. He could not accept this interpretation immediately, remonstrating that he had always hated his father and his inferior position to him. I deliberately offered as an illustration the drinker's relationship to liquor – though he hates it and knows that it is poison to him, he must go on drinking. This apparently made the penny drop.

3. He went on to recall an incident when father saw him fooling about in the bathroom. I asked whether he was masturbating, but he was not; he was indulging in a game that had fascinated him since his early childhood. This game centred upon children's nappies, which for as long as he can remember have had an immense interest for him. He was putting on a towel or something as a kind of nappy around himself.

4. This led him to talk about another practice of his, also going back to fairly early childhood, which is an interest in his anus. He used to play with it, putting his finger up, and he remembers finding a small enema syringe with a rather narrow nozzle and playing with this.

5. This led him to recall all sorts of anal games, both at school with various boys, and with the engineer mentioned in a previous session. He was somewhat uncertain which happened first, but gradually concluded that perhaps the engineer seduced him and then he introduced this into the sexual play with his school-mates. This went on for some time. The last time he took part in this sort of anal intercourse was the time when he was about nineteen or twenty with one of his most intimate school-mates. The only other person who knew about it was Keith, his Jewish friend, who was also party to these games at the age of thirteen or fourteen. Since the age of twenty he has lost interest in all this and though several approaches were made to him in the army he was not interested.

6. Then a pause followed, and overcoming some resistance he admitted two more practices. One was using the enema nozzle to introduce it into his penis and forcing water up his penis, which led to erection and orgasm. This has gone on since childhood until quite recently whenever Farah was away either for a shopping day in London or visiting her parents in Cyprus. The most recent form, several years ago, was to bring the nozzle of the shower against his penis and force water up it.

And the last practice, which he called the electric experiment, consisted in introducing a knitting needle into his penis and the handle of a spoon into his anus and running a low voltage electric current. This he found more stimulating and satisfying.

Recently he talked about all these things to Farah, who warned him that he might cause serious injury to himself.[3] Since then he has not indulged in these practices. Here I interpreted that apparently he must in a way use his penis as a woman would use her vagina, forcing things up into it and squirting water into it.

7. He was rather impressed by this interpretation and as a response admitted that he had always been uncertain about the size of his penis, feeling it was much too small. He even complained to Farah about it, and she tried to comfort him, saying that his penis was perfectly all right; and, compared with that of the other officer which she felt when they were fooling about, Mr Baker's was much more impressive.

8. Here I had to stop because the time was up and I summed up what we had learned today:

(a) that he must always be inferior to any man who represents his father, that he cannot compete and especially cannot win;
(b) that this must somehow be connected with the feminine streak in him which makes him interested in his various experiments, which creates situations in which he has an experience similar to that of a woman; and
(c) because of all this he cannot feel himself as an acceptable and proper man.

[3] This was a remarkable achievement by his wife, but as is mentioned above and will be mentioned on several occasions, she was highly sensitive, loved him sincerely, and – apart from his paranoid questioning – her answers were unfailingly the right ones.

E. THERAPEUTIC INTERVENTIONS THOUGHT OF BUT NOT GIVEN

All this will have to be interpreted in the transference and on several occasions I was near to saying something like: he can talk about these things to me because he feels that I will not humiliate him like his father. He was so much involved in his various confessions that I postponed this for another session.

F. FOCAL AIM

Exactly as decided at the beginning.

G. OUTCOME

Most promising.

COMMENTS ON SESSION 5

Here is a good example of what we call the technique of selective neglect and selective attention in interpretation. Although there was rich anal material presented by the patient, the therapist made no attempt whatsoever to interpret it, but concentrated his attention onto the material leading into the focus chosen by him.

SESSION 6 17 March 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

I expected a further improvement in his state but was uncertain whether he would be able to keep up the pace of the previous sessions. In fact he almost did.

B. ATMOSPHERE IN INTERVIEW WITH CHANGES IF ANY

As previously.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. Started by reporting that he has been much better. True, on Friday and Saturday he was quite finished (his sessions were on Fridays) and he spent most of the time in bed, but then he got up and the whole week was very pleasant indeed. Even his wife remarked that he seemed to be his old self. They were very happy together, both in and out of bed. I interjected that the tiredness and exhaustion was to be expected; after all, he had told me a good many highly embarrassing facts and experiences of his life.
2. He then tried to correct one of my statements in the last session – that he was interested in what a woman feels during intercourse. He thought it was true only as far as her loving feelings were concerned but not further. I insisted that the various experiments reported by him —pushing things into his anus and penis, squirting up water, running an electric current through – can all be interpreted as experiments with a view to imitating conditions that are only true for a woman during intercourse. This he accepted.
3. He then went on to report further events from his childhood. He had already mentioned that his father was a rather crude man who made 'robust' jokes. One of his favourite games was to come up to the bedroom after Mr Baker had gone to bed, pull off the bedclothes, and try to grab his genitals, saying, 'All this is mine, all this is mine.' Mr Baker said this was highly embarrassing, whereupon I intervened and asked whether it was more frightening or more exciting. He replied that it was difficult to say.

They moved from town into the country near the works when he was about 7, and a number of memories of that age came up. He had to go to the village school, which mother strongly resented, and she had tried to enjoin him not to mix with the working-class village children. He remembers a Sunday fête in the vicar's garden when he joined the other children; mother strongly reproached him for behaving like a hooligan.

About the same time he had various severe abdominal attacks that were eventually diagnosed as appendicitis and an operation was proposed. Although he was terrified of it, he had to pretend that this was great fun. Before going to hospital, the vicar arrived out of the blue and informed him that he would baptize him, which made him still more frightened.

At the age of twelve, when he was already at the boarding school, he became seriously ill, with a high temperature, and he remembers that his parents were summoned and took him home. His illness was eventually diagnosed as rheumatic fever. It lasted for several weeks and at the end he was told not to take part in any sports, especially not to play strenuous games such as football. During all his schooldays, he was teased by his school-mates. 'Don't attack Baker. His heart might stop.' He believed for quite a long while that he was seriously ill and would not live very long. When as an adolescent he started to stay out until ten o'clock or even later, father sent him to a doctor who apparently had been instructed to frighten him. The doctor told him that unless he took his state seriously and spent a lot of time in bed, he might not live to see his twenty-first birthday. The result was the opposite. He rebelled, thinking that it would not make much difference whether he died when he was twenty or twenty-two, and he came home very late regularly.

Of course nothing happened and he was passed as A1 in all his army medicals. I interpreted again that all these events served one purpose – to keep him apart from the other boys and make him different from them, make him into a kind of weakling or sissy, which is in good agreement with what we found previously: his interest in the woman's role during intercourse.

4. From there he went on to speak about his mother for the first time. She is a nice woman in a way, but very hard and disappointed. When I asked what he meant by that, he said there is not much warmth in her as she had been completely squashed by father. She is most unhappy and has been pessimistic all her life, and so Mr Baker never had any support from her. I used this opportunity to interpret that what he especially cannot understand is how a nice woman like his mother could have fallen for a crude man like his father, in the same way as he cannot understand how Farah had been able to fall even temporarily for the other man.

5. This he accepted, and reported a fantasy that he has had for a number of years now – that Farah has sexual intercourse with another man – which is highly exciting, but he must be present all the time. Interpretation: this is exactly what he tries to achieve by pressing Farah for more and more details about her affair with the other man. Not only must he be there and know all the facts, but also he must know exactly everything that she felt.

This was also accepted, and then he went on to say that he can understand how Farah could be *sexually excited* but not how it was possible for her to have thought seriously that she *loved* the other man. When I asked him whether he had ever found any other woman agreeable or exciting he reported a number of occasions when this did in fact happen. Once in Italy during the war he seriously thought that he might fall in love with a very, very nice Italian girl, and, in recent years, when he and his friend, Keith, on a few occasions went to France together without the women, and were then on the loose, they had great fun, gambled in the casino, went to low nightclubs, etc. On one occasion a girl in the nightclub started to fool about with him and he was almost willing to follow her upstairs, but didn't. Another time, in Paris, they picked up a pretty American actress who took them around a lot of nightclubs. By the end of the evening they were half drunk, and coming home he tried to get into the girl's bedroom, but fortunately the door was locked. I interpreted here that though it is unquestionable that he is very loyal to Farah and is sincerely in love with her, it was possible for him – though for short periods only – to forget her completely and find another woman very attractive. Apparently what he cannot accept is that any man might become a rival to him.

We then went over some old ground again, especially the fact that he is immensely interested in what might have happened between father and mother and between Farah and the other officer, because he simply cannot imagine that in Farah's case he scored a complete victory. This cannot be, because his rival, father or the other man, might upset everything at any moment.

6. He responded by saying how much he enjoys coming to see me and discussing things with me. We agreed then that he would come next week and then not for a fortnight because of the Easter holidays, at which time we should take stock and decide what the next step should be.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

Nil.

F. FOCAL AIM

Unchanged.

G. OUTCOME

Unquestionably further progress, and I think I shall be able to finish this period of his treatment very soon. This does not mean that he will be cured, but certainly for some months, or maybe even longer, he will be able to enjoy life.

SESSION 7 24 March 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Further improvement.

B. ATMOSPHERE

From both sides, as usual.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. Stated that he had had a very good week, being much calmer and even able to crack jokes with Farah about his various preoccupations. There was only one bad day, yesterday, when after visiting his parents he became upset and was depressed in the morning, could not get up until 9.30 (considerably later than usual), and could not go back to the office after lunch. I interpreted here that this is again unquestionable proof that his jealous preoccupation with Farah and the other officer is connected with his relationship to his father.
2. This was accepted as self-evident and he reported that the day after he went out with his friend, Keith, to his club. They had a few drinks and he discussed his problems with Keith (who has known about them all the time), and Keith talked about his own marital problems. There was a loose woman among the guests who tried to pick them up in a rather manifest way, but they did not respond. On the other hand, there was also a very pretty barmaid who made a great impression on Mr Baker. He found out that she was German, and he thought she was very pretty indeed. Next day when Farah went to the airport to fetch a French boy who was staying with them on an exchange visit with their elder son, he was alone in the house and as usual had to masturbate,

this time with the German girl in his mind. In fact, as he admitted with some difficulty, he masturbated three times.

Then it became clear that he had completely confused the events and could not remember on which day what had happened. After some difficulty we sorted things out: that it was Tuesday evening that he went to the club, Wednesday that he was miserable and went in the evening after dinner to his parents, and Thursday that Farah went to the airport to fetch the French boy. I commented here that it was not so easy to remember the events in exact detail, and he must realize that if he cannot sort things out over such a short space of time, how could Farah do it fifteen years or more afterwards? He laughed rather guiltily but I think the comment went home.

3. We then went over old ground, partly with regard to his father, during which he added further details about how overbearing and unpleasant he is, and how Mr Baker cannot stand up easily to him, although recently since coming to me, he has been able to be much firmer with him than previously. I linked this up again with his inability to win in competition with a man, whether it was his father or the officer.

He responded by going over the same old story in a long and complicated way in which he again brought up his old problem of the difference between sex, love, and companionship, and which of those three can he accept more easily as being felt by Farah towards his rival? I must admit that I soon got lost in his complicated argument and in no time I was uncertain myself which he can tolerate least: (a) that Farah felt sexually aroused by the other man; (b) that she thought she was in love with him; or (c) that she felt she had found a companion in him. Gradually, however, things improved and he concluded that the least disturbing thing for him was to imagine that Farah was sexually stimulated, or even that she had a kind of orgasm with the other man. What he cannot bear is that Farah might have felt romantic love for him or thought that he was a companion for life.

4. He recounted again the time he spent alone in India. It was about nineteen months altogether, of which the first fourteen or fifteen months were all right, though rather miserable because of his loneliness. Then he got dysentery and just before going to hospital got the curious letter from Farah telling him two remarkable things: (a) Farah's father had intercepted a letter from Mr Baker's sister to Farah and made an awful scene because his daughter still had contact with the man whom

he did not want her to have; and (b) that she was miserable but hoped to remain human. He sent a telegram to her office asking her to remain faithful to him in spite of all the difficulties. Then a pause followed of about five weeks, due partly to the fact that Farah did not write to him and partly to the delay in his letters being forwarded to him from his unit.

Then the letter arrived in which Farah told him that though she felt hesitant about the other man, she had given him up, and this started off his ruminations. It was about three or four months later that he returned to Cyprus. Farah confessed what had happened and, at their third or fourth meeting, he told her that if she thought the other man was more suitable for her, he was willing to stand down, although it would be very difficult for him to do so. This was the turning-point and from then on everything went all right until after their marriage.

5. We reached the end of the session and in view of the coming Easter holiday we decided to meet in a fortnight. He asked me whether I thought he should still come regularly every week. I told him I must leave the decision to him and perhaps this fortnight would be a good testing period. He then asked me whether he should bring Farah along at the next meeting and whether we three together should discuss the problems and how to handle them.

6. In view of my ideas (noted under 'Interpretations thought of but not given' in the last few sessions) I inquired what he thought was the reason that talking to me made such an important difference to him; after all, he told the same things, for instance, to his friend, Keith. He was rather interested in this question, but could give no cogent answer. The only important aspect he could find was that with me the whole atmosphere was quieter and one has time to allow things to affect one.

We stopped here.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

None.

F. FOCAL AIM

It is remarkable how both aims given in the first write-up are running parallel. Until now I have described as my more ambitious aim to allow him to enjoy his victory over father and the other officer.

After having done quite a lot about this aim, he himself is proposing to bring his wife to me, to 'share her' with me, so to speak. It is likely that we shall end this period of treatment on that note.

G. OUTCOME

Most satisfactory for the moment.

COMMENTS ON SESSION 7

C.&D. 2 is an instructive example of telescoping for defensive purposes. The therapist is not bothered about the various sidelines offered, as he would be in a proper analytic or long-term psychotherapeutic work, instead he goes straight to interpretation of the only aspect of this complex event that leads directly to his chosen focus.

SESSION 8 7 April 1961

Length of interval since last session: 14 days

A. INITIAL EXPECTATIONS

Expected further improvement and easing of tension. On the other hand, I did not know in which way the interview would go as he had proposed to invite his wife to be present.

B. ATMOSPHERE

As previously. No change.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. He came alone, did not mention his wife's not coming at all, and reported that after the last session he had had three rather bad days, was unwilling to get up in the morning, go to work, etc., but this disappeared and he then had perhaps the best week or ten days for years. Yesterday he again felt somewhat edgy, possibly because Farah went to the airport with the French boy, or because he had to come to see me, or because he had to occupy himself more with his parents who have come to live in a hotel near his house while their own home is being redecorated.

Whenever he sees his father, he feels a pressure in his stomach, a kind of apprehensive expectation. Father still has a very forceful personality,

and it is very difficult to resist him. Mother's way of treating him is passive resistance; she just sits and cannot be moved.

2. Then he again started his complicated ruminations about what might have happened between Farah and the other man. I let him go on for some time and then summed up the situation that apparently there are two facts that he cannot accept: (a) that for some time – we established it was eight months between the time when Farah met the other officer and Mr Baker's return from India – Farah was uncertain, both sexually and emotionally, which man would be the right partner for her for life; and (b) that after this period the decision was made and he had won.

3. On the one hand he accepted that this was so, and on the other he brought up two new topics: his need to idealize Farah, who to him must be a kind of immaculate Madonna, at any rate until the time when she had fallen in love with him; and, second, the fact that her having felt something similar for another man is intolerable to him – Farah herself has on several occasions protested violently against this idealization, but he cannot help it; picking up a remark made by me some sessions ago, he said that apparently he feels that really the other man ought to have won and in a way it was cheating that he had got Farah.

4. I linked this up with his relation to father. There, too, he cannot accept the fact that for some time there was a struggle between them and now the fight has been decided. He is the managing director of the firm, that is, he has won.

5. That reminded him of a story that mother told him some time before the war, according to which she was in love with a man, but for some reason or other could not marry him, and then father turned up. He was so pathetically in love with her that out of pity she married him. Mr Baker remembered that after his return from India he had a long discussion with Farah in which he gave her freedom to choose the other man if she felt she wanted to; when they parted he walked back to his flat and it came to him that if Farah chose him, it would be an exact repetition of his parents' marriage. When I underlined this, he got really frightened because this is exactly what he does not want; his parents' marriage is simply horrible, and he added hastily that at least he is trying to do something about having a better marriage by coming to see me.

6. This led him to report another incident that happened last week. Father as usual teased Farah about her French-English pronunciation

by talking to her in broken French. It was an unpleasant situation, but Farah did not mind it very much. On the other hand, Mr Baker came down rather heavily on his father and simply squashed him. That was a great satisfaction to him though he realized afterwards that father had been very badly hurt.

We then talked a good deal about his father's cruelty, and said that he must hurt people in order to hide his own insecurity, and I made a parallel of it to Mr Baker's cruelty, in particular towards Farah whom he must hurt all the time because he feels that he has cheated her into marriage.

7. This was the end of the session, and I asked him why he had decided not to bring Farah. To my relief he said that thinking it over he thought it was much more important that he should clarify things with me independently from her than be still more dependent on her.

8. We then discussed the future and decided that he would continue to come in order to consolidate results already achieved and so make further progress.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

None.

F. FOCAL AIM

Maintained, although the second, sharing his wife with me, has again receded.

G. OUTCOME

Fairly satisfactory. I intend to give him another six to ten sessions, but certainly not more.

COMMENTS ON SESSION 8

What follows here could have been said either earlier or in relation to many of the subsequent sessions. We mean the habitual, repetitive cycle reported on many occasions by Mr Baker, namely that either immediately after the last session or only one or two days later he felt poorly, unable to get up, unwilling to go to work. All this then disappeared and during the rest of the interval he felt much better and was quite happy

with his wife. This would very probably offer a most welcome entry into studying some aspects of his ego structure or the nature of his reactions to the therapeutic process, the adhesiveness or liberty of his libido distribution, for example. All this could have been attempted in a long-term psychoanalysis or even in an analytically oriented short-term dynamic psychotherapy, but here it was treated with selective neglect. The reason for it is that it would have deflected the therapeutic process from the focal area. (See C&D 1.)

Two further comments must be made here. The first is also about selective neglect: the very rich material produced about his oedipal conflict was accepted, but not interpreted. Instead, the therapist interpreted only the aspect that led the associations towards the focal area chosen. Second, at this time the therapist thought that the treatment could be terminated in about 20 sessions; in fact, taking the follow-up sessions into account, it went on for 29 sessions.

SESSION 9 14 April 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Further improvement was expected and proved to be correct.

B. ATMOSPHERE

Friendly and cooperative. Maintained from both sides.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

Practically the whole session was occupied by him, and I made only a very few comments. Almost the whole time was taken up by one theme, and it would be rather difficult to report it in isolated paragraphs.

This was one of the best weeks of his life, with only one very slight setback. On Wednesday he had to take part in a business dinner, which meant being up late and mixing his drinks. In consequence, next day he was a bit under the weather. On the other hand, coming up to meet me he was not occupied all the time with his thoughts about his illness but enjoyed the drive.

He then asked whether he could use notes that he had made immediately after the last session. I agreed, and the notes turned out to be centred upon one topic, which then became the main theme of the session.

This topic is his fear of 'utter loneliness'. It took some time for him to convey its real meaning. It means that he has been dropped, that someone important to him does not think any more of him, that he has been forgotten and abandoned. That was what he felt – and dreaded – on receiving the confused letter from Farah when he was in India. All his questioning of Farah had been aimed at ascertaining that even when she was hesitating between him and the other officer, she had not completely dropped or forgotten him. From here he went on to some of his war experiences, when he was alone under heavy shell-fire. On each occasion he was very distressed that if anything happened to him Farah would know nothing about it; he would be completely lost.

He then inquired whether this could have anything to do with his childhood experiences, especially with the bad treatment that he received from his father who, on many occasions, almost regularly, behaved to him with utter unconcern, as if he did not exist at all or was a lifeless object. True, if anyone outside criticized or attacked him, his father would rise to his defence – but that was not from concern for him, but only because Mr Baker was his father's son and, so to speak, belonged to him. I interpreted here his marked dependence on father in the past – and on me at the present time. This dependence might explain why he so easily accepted any homosexual approach, especially if it came from a man who was his senior or superior: the engineer, the older boys at school, and me.

In response, he recalled a number of details already discussed and added a new item – his fear of snakes, which he fully recognized as having a homosexual significance. Characteristically, in the last week he had had a most pleasant dream in which a big snake, a very friendly creature, snuggled up to him and put his head in his lap. He was not afraid at all. Of course, this was interpreted in the transference.

That was the end of the session and we agreed that in view of my coming holiday he would certainly come for sessions for the next four Fridays, after which we might consider discontinuing the treatment.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

None.

F. FOCAL AIM

Maintained, and I was glad to extend it to include the transference. I have to watch now to bring out his feelings of mourning about the coming separation of the two of us.

G. OUTCOME

Most encouraging.

STRUCTURE OF SESSION 9

We shall try here, for a few sessions, only to follow the therapeutic process in detail; that is, the patient's 'offers' and the therapist's 'responses' to them, which is then followed by further associations and offers by the patient.

After Mr Baker was able to stand up to his father and to 'squash' him (as reported in Session 8), he took matters into his own hands. The chief result of this increased self-reliance was the revelation of a new over-determining factor in the causation of his illness, his dread of 'utter loneliness', which means loss of the love of his most important object of the moment. It was this that was perhaps the most important factor, that disquieted him in India and forced him to sever his relationship with Farah, almost immediately upon his return to Cyprus.

It was he who then went on, comparing these experiences with highly ambivalent childhood experiences, connected with his father. This opportunity was then used by the therapist to work out the similarity between his homosexual and heterosexual dependencies.

This interpretation was confirmed in two ways: (a) by his recollecting his childhood fears of snakes, which he already then experienced as having homosexual overtones; and (b) by a recent dream in which a big snake, a friendly creature, snuggled up to him. This was interpreted as illustrating his transference feelings.

SESSION 10 21 April 1961
Length of interval since last session: 7 days.

A. INITIAL EXPECTATIONS

I expected further progress and further work.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. Against my expectations he brought his wife, and the first part of the interview was with the two of them. Farah was very prettily dressed and looked, though somewhat embarrassed, quite happy and calm in a self-assured way. Mr Baker was at home, reassuring and protecting his wife. Both of them unanimously stated that the last week had been one of the most peaceful and most harmonious of their lives, and they were genuinely gratified and grateful. The only thing that emerged from this joint interview was the mutual idealization of the two partners. Each of them talked about the other in terms of perfectionism. I pointed out that this must create a very nice and warm feeling in the speaker, but to live up to those very high standards must be rather an oppressive burden for the partner. They were somewhat surprised, but accepted it. Then it was decided that the interview should be continued by Mr Baker and myself only.
2. Very little new material was brought up. Almost the whole session was taken up by going over old ground and repeating the results that we had achieved. I allowed it to happen without much interference.
3. Then we returned to a remark made at the beginning of the session, that on Sunday Mr Baker was very touchy. He repeated it, and when I asked why it was so, he gave me some further details from which it emerged that he deliberately decided to throw his weight about – somewhat like his father used to do. I interpreted his developing new ability to be like his father, which he adopted with some amusement and pride.

B. ATMOSPHERE

The atmosphere of the session was calm and trusting, as previously, in spite of the appearance and disappearance of Mrs Baker. I accepted it.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

I could have interpreted the appearance of his wife as his attempt at

sharing her with me and as a sign of growing confidence both in himself and in me that this could happen.

F. FOCAL AIM

I think in spite of the sudden appearance of Mrs Baker, my two aims as stated at the beginning of the treatment will be maintained.

G. OUTCOME

No change, but further intensifying of the good relationship between therapist and patient.

STRUCTURE OF SESSION 10

Starting with the delayed appearance of Mrs Baker, who it had been planned should come for Session 8: the original aim of inviting her was to discuss with her her ideas about whether the treatment should or should not be continued. This was not even touched upon.

The dynamically most important material of the session was Mr Baker's report about his becoming deliberately more like his father, in so far as he throws his weight about as his father used to do, of which Mr Baker seems to be very proud. It is possible that this increase in self-reliance enabled him to bring his wife, to share her with the therapist, as it were.

SESSION 11 28 April 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Further improvement but no other change, especially not in our relationship.

B. ATMOSPHERE

No apparent change in him but some puzzlement in me – see below.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

The last week was again very good indeed, hardly any compulsion to ruminate, in fact he did not bother about it until the morning before coming to me. Then he discovered something and told it to Farah, who responded by saying how glad she was, because this was exactly what she had always wanted to tell him but could not express it so well.

He then proceeded to tell me his discovery – but the further he went, the more puzzled and confused I became. Of course, it was about what Farah might have felt towards the other man – sexual excitement, love, or companionship · and how these feelings related to what she might have felt or was feeling towards him, Mr Baker. Although every sentence was perfectly constructed and sensible, the whole thing got me more and more confused. While listening to him, I was hesitating about what I should interpret: his wish to confuse me as he had confused Farah, in other words, his wish to put his own confusion into us; bringing together his doubts over Farah with the original doubts over his mother, i.e. about how these two women could love another man instead of him; and so on. I refrained at the end for two reasons: 1. I was not certain whether any of these interpretations would be quite correct; and 2. they would have taken me away from my focal aim. So I reiterated my by now somewhat shop-soiled interpretation that apparently he still cannot accept the fact that he has definitely and irrevocably defeated both his opponents, that is, father and the other officer. This seemed to have some effect on him, but it may well be that I tried to console myself here. He is coming for two more sessions before my holiday.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

See under C&D.

F. FOCAL AIM:

Maintained under difficulties.

G. OUTCOME AND AFTERTHOUGHTS

He seemed to be quite satisfied with his own discovery and with my understanding of it, which was practically non-existent.

I wonder what this new development means. It is possible that the therapeutic honeymoon has just ended and proper work ought to start

now, and so the first thing he is offering is his confusion. If this is true, it means that the short-term therapy has failed and he has to be referred for analysis. The second possibility is that we have exhausted my original focus and he is offering a second one, that is, his relationship to mother and maternal figures. In this case I shall be faced with the decision either to accept it and start a new period of treatment, or to disregard the offer and try determinedly to work on the two primary foci. Third, there is the possibility that we have finished our job and he is just tidying up some loose ends whereas I, because of my lack of receptiveness, have not been able to see what is happening. In this case, nothing special need be done.

Thus, the whole assessment revolves round a problem of differential diagnosis that must be solved in the next two sessions, that is, before my departure on holiday.

STRUCTURE OF SESSION 11

This is discussed properly under Section G of the Session Report.

SESSION 12 5 May 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Very uncertain, for the reasons given at the end of my last report.

B. ATMOSPHERE

Friendly as usual. No change.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

1. Started by saying that he had noticed during the last session that we were somehow not together. Was I critical of his propositions, or was it only that I could not follow him? I answered that I could not be critical, but it is true that I was somewhat at sea in understanding what he meant.

2. He went on to say that in spite of this he had been very content and confident during the whole week and had felt that the time was pregnant with something important. True, when he arrived last week he was somewhat out of sorts because he had had an argument with Farah. She was driving, it was the first time she had driven in fast-moving, heavy traffic, and he tried to push her beyond what she could do. She made a little mistake, was shouted at by a man in another car, and when the incident was over Mr Baker and Farah had an argument about him pushing her too hard.
3. Something similar happened yesterday. He was too lazy to go to work and allowed Farah to take their daughter to school in the car. When she came home, he heard a big bang but did not jump. When Farah came in, he asked what had happened, which she resented, but she answered that she had hit the gate-post. When he asked if she had examined the car for any damage she said no, but was very resentful indeed. He became peeved and could not help comparing this incident with Farah's inconsiderateness when she was carried away with the other man.

I was fully aware that this opened up a new line away from my original focus, but felt I could not ignore it completely; I interpreted that whenever he is hurt, he must respond by reproaching Farah for her past deeds, that is, hurting her back, and thus quite a large part of his obsessional nagging and pestering Farah with questions is nothing but using the past to beat her with. He did not like it but had to accept it, and this was the first time he was able to tell me the name of his rival – James.
4. Then we went on again, chewing over past material about what Farah might have felt, whether she was fair or unfair, considerate or inconsiderate, understanding or not caring, etc. I let him go on for most of the time and chipped in here and there, rather gently linking up this general attitude of his with certain aspects of the present, including his transference to me. The whole thing was more a recapitulation than bringing up new material.
5. At the end of the session he mentioned his interest in the Rorschach test and asked whether I thought there would be enough change in him after the effort of our joint work, to justify another Rorschach. Instead of interpreting this as a kind of vote of non-confidence in me, I accepted it and said that if things remained as peaceful as they were now, it would be worth while having a re-test after we have seen each other a few times in June. This was agreed upon.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

Some transference interpretations, such as beating me up with his ruminations, showing his doubts in the efficiency of my technique by asking for a re-test, etc.

F. FOCAL AIM

Shaky for the first time. He presented his aggressiveness to Farah, which I had to interpret, but I still think that on the whole I was able to maintain my original aim. This, of course, will be seen only after some further sessions.

G. OUTCOME

Some consolidation. Not much further progress. It will have to be seen whether this is the beginning of the tailing-off period or the emergence of a new thing that has to be solved before finishing the present course of treatment. I think it will be the first.

STRUCTURE OF SESSION 12

The uncertainty continued. The material produced by the patient continued to be equivocal and the therapist could not become any more certain whether the work was going towards his focus or not, in which case all sorts of complications had to be considered: like starting a new phase, tailing off the treatment, choosing a new focus, etc., etc.

SESSION 13 12 May 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Very uncertain in view of the impending break caused by my holiday.

B. ATMOSPHERE

He was much more serious and pensive than usual, and I got rather confused early in the session in trying to follow his obsessional ruminations. Later I was able to re-establish our usual relationship.

C.&D. MAIN TRENDS AND THERAPEUTIC INTERVENTIONS GIVEN

He had had rather a bad week with a lot of obsessionalism. The main cause was that Farah was away visiting her sister. A further disturbance was caused by Farah ringing up saying she would not be coming home until Monday lunchtime instead of Sunday evening, as she was going to do some sightseeing with her sister. This rather pained Mr Baker as Monday was their wedding anniversary.

Then he got submerged in his endless ruminations about the real meaning of what Farah had felt towards the other man, James. I soon got lost and was able to regain ground only after considerable effort. What emerged was roughly this. Farah was just as much fixated to her father as Mr Baker was to his. As Mr Baker was not acceptable to Farah's father, Farah tried to find another man who would not take her away from Cyprus, and found him in James, whose family was resident in Cyprus. Then we came back to the aggressive aspect of his ruminations and questioning. He unquestionably tormented himself by them, perhaps to a larger extent than he tormented Farah, but undeniably he tormented Farah too. The question to be solved was why he had to do it, what was the gratification that he gained by it, and what else could be given to him in substitution.

For the first time in our therapy he seriously accepted this aspect and then turned to me and asked whether my treatment would be able to get him what he really wants – freedom from these obsessional ruminations. I got somewhat frightened because this was a straightforward request for proper analysis which, in view of his illness and of the distance that he has to travel to London, is not a very practical proposition. I thought it best to temporize and so I proposed that we should use the impending break as a kind of test period to see how much he has gained by this therapy and then we would decide this most important issue in the light of his state after the break. This he readily accepted.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

I asked myself only after the session was over whether his questioning me about his future could not have been interpreted as a displacement on to me of his urge to torment people – which may be true but not easily acceptable to the patient.

F. FOCAL AIM

Somewhat shaky again.

G. AFTERTHOUGHTS

I really do not know what to expect next. On the one hand, it could be considered as an excellent result that a paranoic patient asks for treatment. On the other hand, the prospects of a proper cure are not very high in paranoia. Still, in view of the very easily establishable good relationship this should be considered seriously. The next question is frequency and choice of the future therapist. Evidently he cannot come five times a week to London, but it is rather doubtful whether anything could be achieved by seeing him once or perhaps twice a week. Another possibility is to refer him to an analyst who is about to settle in his neighbourhood. The referral will not be very easy, but perhaps it can be managed because he has great confidence in me now. On the other hand, this good relationship will make it rather difficult for him to transfer his loyalty to someone else. In conclusion, I do not know, for the first time in this treatment, what to expect.

STRUCTURE OF SESSION 13

A newly found topic – that of fear of 'utter loneliness' or being abandoned by his most important object of the moment – turned up again, but hardly any progress could be made. The situation remained uncertain and the focus somewhat shaky. Compare with Section G. – Afterthoughts in the Session Report.

SESSION 14 23 June 1961

Length of interval since last session: 6 weeks

A. INITIAL EXPECTATIONS

We had made an appointment for last Friday, 16 June, but he rang up during the week and said that he was on holiday, felt very well, and asked whether he could postpone the interview by a week. I agreed.

In view of the ending of the last session (no. 13) and the good news

from his holiday, I was rather uncertain what would happen, but on the whole I was confident that the improvement would be maintained.

B. ATMOSPHERE

At least as friendly as usual, perhaps even more friendly.

C.&D. MAIN TRENDS

He reported that he was practically all right, some obsessional ruminations but no compulsion to think all the time. He had a very pleasant holiday with Farah and they are really happy together.

He realized how hypocritical and smug he used to be, censuring in other people what he committed himself. For instance, he was definitely attracted by women, but had to express, even to himself, his feelings in sublimated terms, such as, that the woman had a beautiful voice, a very nice personality, or when he liked her breasts, he had to say to himself that she had a good figure, and so on. Now he can enjoy life without trying to be secretive or smug about it.

This is also reflected in the fact that he would like to change his car. He has a closed-in, reliable, sluggish car. Now he would like to have an open, fast car, so that he can feel he is really in the world, not outside it in a closed-in atmosphere.

His relationship to his father has changed also. Until now he has always been anxious or irritated in his presence, now he is either rather indifferent towards father or just tolerates him. He feels no excitement at all, but rather pity.

One remark that I made last time stuck in his mind, and he began to see how much I was right in describing his attitude. I had said that his obsessional ruminations were an attack not only against Farah, but against himself – he had to punish himself. Now he realizes that this was true. He simply could not accept the fact that he was hurt by Farah, but possibly also he had stood in Farah's way towards another and had taken her away for himself. Possibly he could not tolerate his own victory, and had to punish himself for it.

During the whole time I hardly said a word. Certainly no interpretation was given. At this point I proposed that as things seemed to be going so well, perhaps we could think of tailing off the treatment. He accepted this readily and suggested seeing me in about five weeks' time. In fact, we agreed on 11 August, which is seven weeks. I then proposed that he should have a re-test in order to have some further

material on which to base the final decision. This was agreed to and we asked the psychologist on the telephone to give him an appointment towards 20 July.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

I deliberately refrained from interpreting anything as I did not want to involve him in any further therapeutic work.

F. FOCAL AIM

Remarkably maintained during the whole treatment, namely, that he should be able to accept the fact that he defeated his father and his rival. This proved to be the true focal area and the bulk of the work was done on it.

G. AFTERTHOUGHTS

Of course, he remains a fairly paranoid man, but unquestionably the treatment has helped him to re-adjust himself and we can perhaps look forward to a considerable quiet period.

COMMENTS ON SESSION 14

A session after a long break of 6 weeks. A typical after-break session. A great deal of re-capping, on the whole emphasizing the improvements. The only new material was his realization that the constant questioning and tormenting were directed not only at Farah, but also against himself for taking Farah away from a possibly better man, James. Definitely an important step.

No interpretations were given. Somewhat reluctantly the therapist accepted that perhaps he and the patient were going to finish their work; and according to the research rules of the Focal Therapy Workshop, the therapist proposed a re-test for which the patient had already asked in Session 12.

STRUCTURE OF SESSION 14

This session was preceded by a fairly long break (six weeks), the second during the treatment. (The first happened between Sessions 2 and 3 and

lasted 15 weeks.) This time he remained well during the whole break, and the material he presented during the sessions allowed an interpretation that the treatment was tailing off and that we consider termination. He certainly accepted quite openly in his associations focus number one; namely, that he won a victory over his father and James. In consequence, a repeat of the psychological testing was arranged. It was done this time by a man who was a member of our research team and, being the senior psychologist, helped the woman psychologist who did the first test to write her report.

SESSION 15 11 August 1961
Length of interval since last session: 7 weeks.

A. INITIAL EXPECTATIONS

About a fortnight before the interview his wife rang up asking me what she should do as her husband had told her that on several occasions he had picked up prostitutes and had had himself masturbated by them. We quickly agreed on the telephone that no immediate action was required but that she should tell her husband that she had rung me up and should ask to come with him at the next interview.

Meanwhile the psychologist's report arrived. To my surprise the Rorschach test fully confirmed the hopeful opinion expressed in my last report. Although these two pieces of news contradicted each other, I remained confident that the symptomatic improvement in his state would be maintained and the alarming new development would prove to be of an ephemeral nature, that is, a passing symptom of his underlying paranoia.

C.&D. MAIN TRENDS

Although Mrs Baker rang up the day before to ascertain the exact time of their appointment, they in fact arrived an hour later, very probably due to a slip of memory on her part. Fortunately my next session was not booked so I was able to see them right away.

We started with a joint interview. Mrs Baker reported that on three different occasions within a few days Mr Baker disappeared, picked up some young prostitutes, had a session of masturbation with them, and then reported the whole affair to his wife. As on each occasion he

seemed greatly relieved after the experience she was put in a difficult situation. On the one hand she heartily disliked the whole affair – especially the last one when after making love to her in the afternoon he pretended to go back to his office but instead picked up a girl of twenty (Mrs Baker is in her early forties); on the other hand, she is very pleased with the great improvement in his state and of course would not like to do anything to upset him. Mr Baker added that all this meant a great liberation to him. All his life he has been inhibited in the presence of sexually attractive women and his present experiences meant that he can get over this inhibition. On the other hand, he would hate it if he had to do it in secret, hiding it from his wife. This would mean (a) that he was ashamed of what he was doing, and (b) that the secrecy would impose a serious strain on their relationship, severely endangering their harmony. Mrs Baker, who is quite an attractive woman, started to weep at this point. I summed up the situation that apparently Mr Baker's liberation has to be paid for by Mrs Baker's pains and that there is a real problem to be solved: how much liberation is to be achieved at the price of how much suffering? A silence followed and I used the opportunity to ask Mrs Baker to leave us, which she readily did.

We had only about a quarter of an hour left and so unfortunately the rest of the interview had to be somewhat hurried. Mr Baker emphasized that he did not want to get involved with these girls; what he wanted was something like this: go to a showroom, pay a small fee, and take one or other of the new models out on the road to test them, then return the car and no further commitment exists. He contrasted this with the German girl, who has now moved to an elegant bar where he occasionally drops in and has a drink and a few words with the girl, but he would never think of offering her a week-end or an evening in London, although he is quite certain that the girl would accept it. This would be a commitment and he does not want that. One more reason for picking up prostitutes is that in his mind it does not mean that he has been unfaithful to his wife, since the girls do not mean anything to him except some sexual stimulation and pleasure. No love is involved.

Our time was up and I had to do something in a hurry, as my next patient was already waiting. I thought it inadvisable to interpret the whole situation so I proposed that we should see each other at least once more. He readily agreed but asked me to have a word with his

wife. I accepted, but she was not in the waiting-room. Mr Baker volunteered to fetch her from the car outside my house and send her up alone, which put me in a rather invidious position. Fortunately we had not fixed the time of the next appointment so he had to come up himself – to my great relief. We had a short talk, agreed on the date of the next interview, and then they departed.

B. ATMOSPHERE

No real tension between the two, although Mrs Baker was somewhat shaky. Mr Baker was his usual friendly self, but there was an undertone of grimness in him that was definitely a new phenomenon. As will be clear from this report, I was definitely hustled and in this way my contributions were somewhat uncertain.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

Of course there were quite a number. (1) No attempt was made to clarify who caused the mistake in time. Was it the ambivalence in Mrs Baker, or was it a collusion between the two? (2) Although I interpreted the similarity between the previous obsessional questioning of his wife and the recent imposing of strain on her by reporting his escapades, I refrained from bringing out the other and perhaps more important similarity: he does something similar to the prostitute to what his wife allowed the other man to do with her while Mr Baker was in India. I am fairly certain this is the real mechanism of the liberation and I propose to work this out at our next interview. (3) And lastly, there is evident transference interpretation: if I propose to terminate the treatment he produces new and alarming symptoms. Very likely this was one of the determining factors in his homosexual experiences. He wanted to draw his father's (headmaster's) attention to himself. This too will have to be dealt with in the next interview. (4) If I am right about (3) I think that the fact that the acting out happened in heterosexual and not in homosexual directions is a favourable sign that also must be interpreted in the transference. (5) The symbolic action at the end of the session was not interpreted either. What it very probably meant was (a) he unconsciously offered me his wife to be used as the prostitutes were, and (b) he resented it, wanted to catch me or her out, that is, reinforcing his paranoid jealousies.

F. FOCAL AIMS

I cannot state anything as I am rather puzzled. Must wait for further developments but if possible I would like to stick to my guns.

G. OUTCOME AND AFTERTHOUGHTS

There are many ways in which the recent development can be explained. (a) If the psychologist's report is correct about the considerable easing of the fear against the phallic women, his acting out might be thought of as a come-back with a vengeance against one of them, that is, his wife. (b) Of course prostitutes always mean getting involved with all the other men who have had relationships with them and thus may be an expression of his underlying homosexuality. (c) All this may be complicated by his basic paranoic processes: he feels damaged by his wife and must retaliate in kind. (d) And lastly, there are all the transference implications. All this has to be watched at the next interview.

COMMENTS ON SESSION 15

In spite of the great improvement of the clinical picture which was confirmed by the Rorschach, Mr Baker apparently took matters into his own hands and decided that he needed more treatment. The therapist saw no other course but to agree.

SESSION 16 18 August 1961
Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Unchanged since the last interview. I did not know whether we were starting a new period of treatment or what.

C.&D. MAIN TRENDS

1. Against my expectations his wife came with him and insisted that she should come up and have her say first. What she wanted to tell me was

that she had had a fight with herself about her husband's recent escapades and had come to the conclusion that she should not make heavy weather of them. They were unpleasant, but provided they did not endanger her marital life she was willing to put up with them. Of course, it would be quite different if her husband got involved with any of these women. Mr Baker had no comment to make, so his wife left us.

2. Mr Baker then told me that things were now much better. He is quiet, does not feel any more urge for any acting out, and moreover he thinks that this thing is finished for him. He now feels free to appreciate an attractive woman, even to feel somewhat sexually stimulated, and is not ashamed of it, but this does not mean that he wants to do anything further.

His relationship with Farah has become much better; perhaps he has never in his life felt so close to her as he does now. Here I interjected that perhaps this is due to the fact that in a way he has paid her back. At first he did not understand what I meant so I had to state explicitly that he did something similar with his woman on the side to what James had done with Farah in Cyprus. After some reluctance, he accepted this but commented that there was a difference: Farah had been emotionally involved, whereas he remained uninvolved.

3. A long discussion followed about the difference between sexual excitement, sentimental emotions, and real love. I let him go on without interference.

4. He gradually warmed up and dropped his somewhat distant and stern attitude and reverted to his old friendly self. He then turned to me and asked point-blank what had happened to him. I accepted the challenge and pointed out that in addition to paying his wife back, that is, getting into closer contact with his aggressiveness and his having been badly hurt by Farah, he was able to talk frankly and without restraint to a man, sharing all his problems, doubts, and feelings with him. He liked this idea, whereupon I went on and said that perhaps his relapse was a kind of protest at giving up this kind of relationship which meant so much to him.

5. Instead of responding directly, he told me that his mother had been very ill for some time and he was afraid she might become psychotic (old age). A few days ago he visited her at his brother's (mother cannot be looked after by father so she moved). He sat on her bed and they talked about her childhood and marriage. She was very unhappy as a child, lost her father when she was eleven, and her mother when she was

twenty-two, felt very lonely, and soon afterwards married. She complained how little father understood her. Mr Baker thinks he helped her by pointing out that father too had had a very bad childhood and needed a lot of understanding. Mother seemed to be relieved somewhat and they parted good friends.

He then talked about father with whom he is quite detached. Father does not make him feel insecure any longer; it does not matter if he comes blustering into his office, and so on. Mr Baker can easily take it. 6. Our time was nearing its end so I asked what our future plans should be. He said that he felt all right and did not think that he needed any further help for the time being, but he would like to remain in touch with me in case he did need more help. We agreed that whatever happened he would either drop me a card or come for an interview before the middle of November (before I go to America), but should any alarming symptoms occur before then, he should get in touch with me.

He was now his old charming self and talked quite freely about his pleasure in having been able to talk about all the things that worried him. He thanked me profusely and then remembered that the real reason for Farah coming to London was to thank me for what I had done for her husband. I replied that I thought he had thanked me both for himself and for Farah, and I did not think it was necessary to recall her from the car. He was rather pleased, accepted my proposition, and departed.

B. ATMOSPHERE

As described, he started with a rather detached and stern attitude which thawed out gradually and gave way, at the end of the session, to a really warm atmosphere. I think I changed attitudes parallel with him, although almost certainly not to the same intensity.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

Apart from E(1) of the last session report, all the interpretations were worked with to a more or less adequate extent, some of them explicitly, some of them being implied.

F. FOCAL AIMS

Maintained. He was now able to accept that he was the winner, and could accept his victory over all the other men, including father. On the

other hand, I think he was enabled to carry away the therapist as a good object to whom he can always return should he be in trouble.

In contrast to the first aim, which was achieved in reality, the other focal aim, sharing his wife with me, was achieved symbolically in the last two interviews. I think the fact that I did not accept his offer to recall his wife to thank me, which would again have been sharing his wife with me, a father-figure in the transference, might even help him to consolidate his victory over the father-figures.

G. OUTCOME AND AFTERTHOUGHTS

I think, on the whole, a satisfactory ending and I think that the follow-up will also be favourable. I intend to follow him up for at least a couple of years.

COMMENTS ON SESSION 16

C&D 2. The patient thus has come to make an 'independent discovery'. He realized what his acting out meant, and in this way reached an insight regarding an important part of his psychopathology.

Would the same result – and with the same convincing power – have been reached if the therapist had interpreted the tendency to act out and in this way had unintentionally prevented it? Or even if he had allowed some acting out and had interpreted right at the beginning of the acting out – so to speak, forcing or offering his understanding and his solutions to the patient?

To our minds, an 'independent discovery' by the patient has the greatest dynamic power, with regard both to gaining insight and to lasting therapeutic change. Of course, allowing some acting out always means taking some risk, because every acting out brings some danger to both the patient and his environment. Here, as on so many other occasions in therapy, the question is not either/or, but what, how much, at what price?

C&D 3. Here again the question arises, should one press for an immediate more complete, almost full insight, or should one allow the patient to make his discovery piecemeal? Here, again, the question is what, how much, and at what price?

The train of associations referred to in this paragraph was unquestionably an attempt by the patient to limit the impact of his

'independent discovery' on himself, overemphasizing the little differences between his wife's possible experiences and his own. The therapist's individual inclination was to let the patient work out his own solution and to interfere as little as necessary by bringing his own interpretation into the patient's work.

C&D 4. seems to show that this policy was successful in this case and gave Mr Baker an opportunity to become more free with the therapist, and, on the other hand, made it possible for the therapist and patient to understand the whole acting out and its repercussions in the therapeutic situation as an important phase of the transference relationship.

Instead of the therapist giving the interpretation that would have completed the verbalization of the understanding of the recent events as transference phenomena, it was the patient who did it, as described in paragraphs 5 and 6.

He was able to show his love and understanding to his mother in a way that clearly shows his newly won identification with the therapist, while the same identification enabled him so to speak to make peace with his father by sympathetically understanding father's difficulty and thus to reduce his own resentment, fear, and hatred of him.

It must be emphasized that the last regularly spaced session was number 13 on 12 May 1961 while number 17 was on 10 October 1961 from which time on patient and therapist reverted to fairly regular therapeutic sessions, that is, in about five months they had only three sessions. True, these sessions were most intense and fruitful, yet it must still be borne in mind that by mutual consent an attempt was made to fade the therapy out. This proved premature, as it was the patient who insisted on having more treatment, to which the therapist readily agreed. (See, for instance, interpretation in Session 16, C&D, paragraph 4.)

With this session we decided to abandon our attempts at reconstructing the structure of each session which we started with Session 9. Our main reason for this step is that a great deal of our reconstruction appeared to be paraphrasing of session reports, mainly outcome and afterthoughts E, F, and G. We hope that the reader will be able to reconstruct the dynamics of each session for himself. In any event, this topic will be discussed in some detail in Chapter 7.

SESSION 17 10 October 1961
Length of interval since last session: 7 weeks, 4 days

PREAMBLE

On 6 October the GP rang up reporting that Mrs Baker had consulted him in great distress; she can hardly bear her husband's constant questioning. Moreover, the GP met one of Mr Baker's friends who was worried because at their last meeting Mr Baker appeared to be very disturbed, almost mad. The GP's main concern was Mrs Baker. He feared that she might break down, and he asked for help. Should he try to tranquillize Mr Baker heavily or send him as an in-patient to a hospital? We quickly agreed that this might be the last remedy, but perhaps first I ought to see them. He agreed readily and was relieved.

Mr Baker rang up on the 7th, a Saturday, but did not find me at home. He left a message that he would ring up later in the day. Nothing happened, but on the evening of the next day, Sunday, the GP rang up again with further bad news. The situation seemed to be untenable. After ascertaining that Mr Baker would be able to drive up to London, I repeated my offer to see them at the earliest possible moment. On Monday morning Mr Baker rang up and I offered him a session for Tuesday, 10 October.

A. INITIAL EXPECTATIONS

Evidently a serious exacerbation, possibly a quickening pace in the development of his paranoia. Still, I hoped that I could make some contact with him and possibly also help him a little.

B. ATMOSPHERE

Very sombre indeed at the beginning. He was practically unapproachable, obsessed by his fixed idea, and on more than one occasion he almost shouted when contradicted. In the third phase of the session when I was alone with him, I gave him some interpretation with remarkable results. The paranoid hostility largely disappeared and the old friendly atmosphere was almost completely re-established.

C.&D. MAIN TRENDS

1. When meeting in the waiting-room, Mr Baker proposed in imperative terms that I should see his wife by herself. Bearing in mind my second focal aim, I agreed. She was really in distress. The situation had indeed

worsened a good deal. When there is a bad period, Mr Baker occupies her for hours, either in their bedroom or in the bathroom, questioning her and twisting every word that she utters. In consequence, she has great difficulty in managing their three children, although they are fairly occupied with their school work. The most recent development was that while discussing with her GP the whole situation, and especially the husband's questioning, it seemed to emerge that perhaps she did not really love her husband when she married him; she did it only because she felt obliged to do so. She added that she knew all the time that it was not true; she was very much in love with her husband, but taking all her husband's merciless questioning and twisting into account, this seemed to be the logical conclusion. Moreover, she felt obliged to tell this to her husband. The result was great pain followed by depression lasting several hours, after which the husband emerged much better and as loving as ever.

I intervened here, showing her how dangerous this game with the truth was. Mr Baker will take this statement at its face value and will mercilessly involve her in still further contradictions. She broke down and cried, professing her innocence and her inability to stand up to him. I sympathized with her but noted to myself that quite clearly she too has her share in the paranoid doubts tormenting her husband.

2. At this point I proposed asking Mr Baker to come up, which she agreed to. He was definitely near-psychotic – peremptory, unapproachable, hardly allowing anybody to speak, and not tolerating any contradiction. For a few minutes I experimented with him, testing his tolerance to contradiction or contra-argument, which was very little indeed. It was during this period that he almost shouted at me. My other purpose was to demonstrate to his wife how to remain firm and not to allow him to twist my words. I think this made some impression on her; in any case, she listened very intently, but I do not know how deep the impression went.

3. After a short while, I asked her to withdraw and I accompanied her to the door. The tension was so great that Mr Baker walked to the window and looked out, turning his back to me. I returned to my chair and started by admitting that I was really worried about him. I had never seen him in such a bad state. He then came back to his chair and asked me point-blank, 'Is it true that I am tormenting my wife?' I replied undoubtedly that was so, but it appears that he torments himself to about the same extent.

He then started a long tirade about his love for truth, about his wife's game of hide-and-seek, that she has secrets that she must hide from him, that he cannot live with a woman who hides something from her husband, that what he asks is only logical answers to logical questions, and so on. I let him go on for quite a long while but remarked eventually that his ruling principle is 'fiat justitia pereat mundus'. This stopped him and after some hesitation he admitted that that was exactly his feeling.

4. This cleared the air to a point, then he reverted again to his paranoid ruminations about what is the difference between love and being in love or being attracted, and so on. I could show him that all these fine and precise distinctions serve one purpose – to trip his wife up and involve her in irresolvable contradictions. He seemed to accept this interpretation because he asked why is it that he must torment his wife and himself to this extent. I repeated my old interpretation that he cannot accept the fact that he had won against his opponent.

5. He then asked what I meant when in the last period of treatment I said on several occasions that he had to accept the fact that for some months his wife hesitated which of the two men to choose, but in the end she chose him. Did this phrase mean that she chose him but loved the other man? I showed him again that he tries to do to me what he does with his wife, namely to trip me up. He knew just as well as I that what I meant was that she had chosen him because she felt that she loved him. By that time the tension had largely disappeared and we were again working together, although the paranoid cloud did not disappear altogether.

6. He then asked me whether there was any possibility of helping them not to torment each other to such an extent. I answered cautiously that in view of the fact that we were able to change things a lot during the winter, we might try it again. He accepted my offer eagerly and we agreed to see each other twice a week for a few weeks.

7. Summing things up I pointed out that apparently he has the compulsion to mangle his wife until she says something that hurts him very badly; then he gets a very painful depression, but after that he can emerge as loving as ever. He became rather thoughtful and proposed that we should examine this process at the next session. He then asked me to come down to his wife to reassure her.

8. I agreed and thought of my second focal aim. My expectation was confirmed when he pushed me forward so that I should go to the

waiting-room alone. I resisted and we went in together. I tried to make it rather short. I sympathized with both of them, accepting that the situation was rather tricky, and strongly recommended to Mrs Baker that she should stick to the truth and should not allow herself at all to be twisted or tricked away from it. I added that Mr Baker's illness is such that he must get an absolute reassurance that what he thinks is right or wrong, but this should not move her to say anything that she does not feel to be absolutely truthful.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

The whole session, lasting more than one and a half hours, was so intense that I do not think I could do anything but keep our heads above water.

F. FOCAL AIMS

Maintained completely.

G. SUMMARY AND AFTERTHOUGHTS

There is a possibility that the exacerbation is an expression of his resentment that I abandoned him to his wife. His behaviour during the course of the session can be compared with that of a jilted lover who then finds his sweetheart still interested in him. This certainly must be interpreted; the only question is in what terms. Should one use homosexuality freely or should one be very cautious? On the other hand, one must realize that this is the only promising avenue for a psychotherapy of his paranoia, and further that what a paranoiac cannot bear is prevarication. Any such interpretation, however, would go far beyond the two focal aims originally stated; so my prediction for the next period is high intensity.

COMMENTS ON SESSION 17

With the therapist's agreement Mrs Baker and the therapist talked to each other for the first time without Mr Baker being present. Session 17 was the most troubled, intense, most paranoid of all so far. The patient's insistence at the beginning of the session that the therapist should talk to his wife all alone, as well as his attempt at pushing the

therapist into the waiting-room so that he should be alone with his wife, shows the correctness of choosing the second focal aim. The session also shows all the difficulties facing a therapist who wants to establish and maintain a reliable relationship with a man as severely ill as Mr Baker. And lastly, the most severe test was the scene in the waiting-room, when the therapist was expected by the patient to reassure his wife. Of course, the therapist did not do that. Instead, he tried to show to her in what way she could perhaps avoid colluding with her husband's illness. These few sentences illustrate how difficult it is even for somebody who is not so emotionally involved to keep to the truth and still avoid the many pitfalls and traps that a full-blown paranoid inquisition must set for anyone.

A further important remark is that under the pressure of the serious deterioration, the therapist has decided to offer his patient twice-weekly sessions instead of the once-weekly frequency hitherto adhered to.

The therapist was uncertain how to understand this serious change. The less sombre idea would be to consider the deterioration as a violent response to the therapist's acceptance that the treatment was about to terminate; the change for the worse would then be a bitter punishment of the therapist's attempt at abandoning his patient. The other, more ominous, possibility was to consider the paranoid illness as an irresistibly progressing process that, though capable of being slowed down, or even temporarily arrested by psychotherapeutic intervention, must run its course eventually. In the next following sessions, this hesitant, uncertain attitude on the part of the therapist is clearly observable.

SESSION 18 13 October 1961
Length of interval since last session: 3 days

A. INITIAL EXPECTATIONS

A very intense period with a good deal of emotion was predicted.

B. ATMOSPHERE

Much quieter, though still not the old friendliness. Apparently his paranoia has progressed and at times he was irritated and impatient, but

I did not respond to it in kind. Moreover, my influence on him was still good enough, so we were able to get on.

C.&D. MAIN TRENDS

1. Hardly any new material during the session. First, a long rumination about how far was it true that he wants to hurt Farah and himself. After a long discourse he reached the conclusion that he wishes to hurt neither of them, and although the fact is that both of them are badly hurt, this is not his intention.
2. From there we went on to a remark that I made on Tuesday, that he and Farah do not speak the same language. After some rumination, he came to the conclusion that Farah uses her words in a different way from him and that leads to a lot of irritation and misunderstanding. I interjected here that in any case it is rather difficult to express exactly in words what one feels. He responded to this in a paranoid way trying to turn it so that I meant that people hide their feelings. With some difficulty I extricated us from this suspicion, but I am not quite certain whether this is final.
3. He then went on questioning why it is that he must relentlessly persist with his questioning. After some time I proposed that he cannot tolerate any disharmony between himself and an important person in his environment. He accepted this and quoted a few examples, all with male friends. I used this opportunity to bring in my interpretation that perhaps this was one of the reasons for his recent bad period, that he felt that we two did not understand each other and that was more than he could tolerate. This too was accepted and he quoted two or three interpretations that originally he understood in one way but now sees how I meant them. The most important among them was that he cannot accept the fact that Farah chose him. He understood it that Farah chose him out of conscience, whereas I certainly meant out of love.
4. This was the end of the session, and we agreed that at least for one more week I should see him twice.

E. INTERPRETATION THOUGHT OF BUT NOT GIVEN

Though I wanted to interpret his latent homosexuality, I could go only as far as the write-up shows.

F. FOCAL AIM

Maintained.

G. OUTCOME AND AFTERTHOUGHTS

Definitely quieter. He mentioned several times during the session that since their last visit things had been much better. In spite of this, there was an air of paranoid suspicion during the whole session. My predictions are highly uncertain though not quite hopeless.

COMMENTS ON SESSION 18

C&D 3. Of course, the interpretation reported here could have been made in various forms, connecting various objects and using various levels. What the therapist did was to emphasize the threatening disharmony in the therapeutic situation while remaining entirely on the whole-person adult level. Alternatives could have been to use Mr Baker's relationship to his former rival, James, or to his father in Mr Baker's adulthood or the same relationship in his childhood. Knowing the very rich anal material from his early life, it would also have been possible to word the interpretation in primitive language using anal part-objects. All this could have been correct and pertinent, but almost all of these alternatives would have led the therapeutic work away from the two foci chosen and would have created the risk as expressed in the jargon of the focal therapy research team that 'the focal therapy would have degenerated into long-term psychotherapy or psychoanalysis'. The only exception could have been using the relationship to James for the interpretation. The reason why a 'transference interpretation' was chosen was that it was the intention to reduce the intensity of the feelings in the therapeutic relationship, which were threateningly ambivalent and high. This was a compromise between focal aim and sheer technical rules in analysis and analytic therapy, but the therapist thought it worth making.

The whole course of the interview began to tilt the balance away from the idea of the irresistible paranoid process and so towards the possibility of the therapy having sufficient power to mobilize integrative forces in the patient so as to achieve an acceptable equilibrium.

SESSION 19 17 October 1961
Length of interval since last session: 4 days

PREAMBLE

Mrs Baker rang up on Monday inquiring whether her husband could bring his friend along for the next session. This was agreed to.

A. INITIAL EXPECTATIONS

Somewhat puzzled about what this new development might mean, but otherwise confident that we should be able to get on.

C.&D. MAIN TRENDS

1. Greeted me most cordially in the waiting-room and proposed that his friend should come up with him immediately as he had important information for me. All three of us went up. His friend turned out to be Keith. The story I got from him was that Mr Baker visited him on Saturday in a most depressed mood, talking about hanging himself in Keith's garage. Keith became rather worried and they had a long talk lasting for several hours. It was decided during that time that as Keith was coming to London anyhow on Tuesday he should arrange to see me.

Keith's idea was that Mr Baker was suffering from a serious inferiority complex, which was started by Mr Baker's father and reinforced by the fact that the family was only a kind of poor relative of the very rich Bakers (Mr Baker's cousin) who owned half the town and were practically millionaires. According to Keith, Mr Baker was a most attractive young man, all the women fell for him, and though he could have had any of them, he always thought that nobody could love him. Then chapter and verse were quoted about how Mr Baker during his courtship with Farah wrote letter after letter to Keith expressing his amazement that such a beautiful and talented woman could have fallen in love with him. Keith thought that this unquestionably contributed an immense amount to the present situation. He thought that the best solution would be for Mr Baker to move out of the town and go to live in another so that he could escape from comparing himself with his rich cousins. I appreciated his help but wanted it to appear in the right light, so I asked each of them whether it was true that each thought the other could have had very great successes with women, but because of their stupid inferiority complex they could not make use of their openings. Both of them agreed, laughing.

2. After Keith left us, Mr Baker explained that though he was depressed, the mention of suicide was only a kind of emphasis and not meant seriously. We then did some work in fitting the information in with the formula that we had found together, i.e. that he could not accept that he – this highly inferior man – could have won in the competition with his rival.
3. From there he went on to ask whether it was true that his upbringing was a kind of conditioning for this outcome. This was speedily agreed to.
4. When I emphasized that the reason he accepted that he was inferior was his great affection for his father, he added that mother was no better either. She also tried to make him feel inferior. I interpreted here the ambivalence that was caused by mother's attitude and which possibly was the reason why he had to torment Farah to such an extent.
5. He confirmed this by mentioning that on many occasions Farah had told him how much he was still tied up with his mother. Then he asked me how it was possible that when Farah visited the GP, she came back with the discovery that perhaps she had never loved him. I pointed out that by his constant questioning he had put such pressure on Farah that she went to pieces and for some time she consciously accepted the version felt by one little part of herself as the whole truth. He saw this point and completed my interpretation: after a couple of hours or so, when Farah was able to integrate herself again, she said that she could not understand how she could have said such a thing. Then the whole sequence made sense to him.
6. He himself then broached the problem of sublimated homosexuality, saying that what he needs is a pat on the back by some man who is important to him, like Keith or me. When he gets it, things fall into shape and he feels much better. That was the end of the session and we agreed he would come on Friday again.

B. ATMOSPHERE

Cordial right from the start, becoming very cordial towards the end of the session when we discussed his positive latent homosexual feelings.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

The only question in my mind was how strongly I should interpret his homosexuality, both in the external world and in the transference. On

the whole, I think it will be better policy to allow him to go as far as he can on his own, and bring in the interpretations when he stops.

F. FOCAL AIM

Unchanged.

G. OUTCOME

Promising.

COMMENTS ON SESSION 19

C&D 1 shows an instructive case of what is called 'milieu therapy' proposed by Mr Baker's friend. It is sensible and it would perhaps relieve the internal tensions in Mr Baker – if he were a fairly healthy man. On the other hand, it is more than questionable what sort of effect this kind of therapy would have on him in his present ill state. Instead of criticizing this proposition, the therapist's response was to interpret the similarity between the two friends, in particular, the idealization and the exaggeration of each other's possibilities with women, as well as the suppressed envy in each of the two friends for these assumed successes in the other. Of course, he did not do it in these words, but asked each of them whether it was true that each thought the other could have had very great successes with women, but because of their stupid inferiority complexes they could not make use of their openings. The acceptance of this interpretation of their mutual envious idealization was signalled by hearty laughter.

C&D 5 we feel was one of the turning-points in the whole treatment. The therapist has enabled Mr Baker to make another one of his 'independent discoveries'. What he discovered was that his paranoid attitude is powerful enough to change *his* world, in this particular case Farah, into becoming incontrovertibly a liar. In other words, he is able to torment her so long that she goes to pieces and then she accepts for the whole truth what one little piece of her is forced to feel and think under the excruciating pressure from her husband. He was also able to make the connection between the tormenting of his wife, Farah's gradually diminishing resistance and eventual going to pieces, and lastly her slow recovery, at which point she had to retract the extorted

confessions. This entire process made sense to him, and he could accept its truth.

Of course, this discovery was greatly facilitated by his remembering all the difficult conflicts in his childhood caused by his father and equally by his mother's character (see C&D 3 and 4). This sequence could have been considered as impressive evidence for bringing together in an interpretation both genetically and dynamically the childhood experiences and the present events. This was 'thought of but not given' for two reasons: (a) because it would have taken the patient's associations away from the foci chosen; and (b) because of the therapist's hardwon preference for working with *Erlebnis* (experiential factors) instead of proving by a correct and clever interpretation that he is miles ahead of his patient in knowledge and understanding. The former method, working with *Erlebnis*, leads to the establishment of a relationship similar to that developing in this treatment, in which patient and therapist are – for the most part, but by no means all the time – almost equals working together on a very difficult task, which remains full of surprises for both of them and stimulates both of them to make 'independent discoveries'. Unless the therapist can really and without any reservation accept that his patient's discoveries are at least as important as his own, i.e. he does not become threatened, insecure, competitive, etc., this equality in the relationship cannot establish itself.

In the latter method, in which the therapist tries to give correct and profound genetic and dynamic interpretations as soon as the material allows it, without waiting patiently for his patient to make *his* 'independent discoveries', a different sort of atmosphere will inevitably develop. In this, the therapist cannot but appear in the eyes of his patient as an incomparably more knowledgeable being, reinforcing the inequality that in the patient's childhood created so much trouble between him and his environment (and foremost with his parents).

C&D 6. The therapist's reward for his patience, that is, for waiting until the patient made his 'independent discovery', was the patient's association. In this association, Mr Baker brought up spontaneously his need for positive sublimated homosexual relationships.

SESSION 20 20 October 1961
Length of interval since last session: 3 days

A. INITIAL EXPECTATIONS

I expected a further easing of the situation.

C.&D. MAIN TRENDS

To my surprise I found that his wife had come with him and Mr Baker proposed to start the interview jointly.

1. Although there had been no further questioning for some days, the situation has become much more tense in the last few days. The main problem was that he could not accept the possibility that Farah had still been in love with him in Cyprus while she felt more or less in love with James. He made his wife repeat several statements that she had made to him that were obviously contradictory.

2. First, in order to help his wife, I pointed out to both of them that these contradictions will go on forever for several reasons. (a) It is almost impossible to express one's feelings exactly in words; words are much narrower than emotions. (b) He demands that his wife should express her feelings in a way that is understandable and unequivocal to him. Quite apart from the fact that they are two different human beings, there is an added difficulty that he is a man whereas she is a woman. (c) He creates a highly oppressive atmosphere by his obvious severe suffering, and blackmails his wife by it to try harder and harder, and by that involves her in even more contradictions.

3. We agreed that Mrs Baker should leave us, and then a long rumination started about being in love, romantic attachment, sexual stimulation, and so on. At times he was in so much pain that he could not sit quietly and had to walk up and down in the room. Although I expressed my sympathy with and worry about him, I remained adamant that what he asks from his wife is impossible. He must accept the fact that he will not be able to get more out of her than – that she flirted with this other man, liked it, started playing with fire, got caught in it, and for some time hesitated which of the two men to choose, but after a while she sorted out her feelings and decided that Mr Baker was the right man for her.

4. This seemed to settle him a bit and we were able to go on with some constructive work. This centred around the fact that he cannot accept that it is possible that anybody could be in love – though with

different intensity – with two people at the same time. This took us quite a time to disentangle. The main trouble seemed to be his jealousy and resentment that this experience (namely, that he felt love simultaneously towards two women) was not given to him. He was never able to lose his head, except with Farah; on all other occasions, whether with men or women, he managed to keep an overall control on his actions. That was the end of the session and we agreed that I should see him on Tuesday.

B. ATMOSPHERE

The atmosphere was very tense, almost hostile, and definitely paranoid (at the beginning), relaxing considerably, being almost back to friendly (at the end).

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

Obviously, for him, the inability to feel in love with two people simultaneously relates to his hetero-homosexual feelings. Unfortunately when he reached that point, we had already overrun our time and I could not bring it in without proper preparation. I intend to do this on the next possible occasion.

F. FOCAL AIM

On the whole maintained, but somewhat shaky.

G. OUTCOME

Uncertain but not hopeless.

COMMENTS ON SESSION 20

C&D 2 and 3 are perhaps a good illustration of the therapist's way of working with paranoia. He does not try to explore or to minimize the importance of the paranoid behaviour, never calls it by any bad names such as mistaken, neurotic, psychotic, irrational, unfounded, etc. He accepts it for what it is: a most important part of the patient's whole mental life. But he does not stop there; he feels that he must let his patient realize, of course at the proper time only, what is the significance of the patient's expectation from the world, how far it is

possible or impossible for the people in it to fall in with these expectations, and what the consequences of his usual behaviour must be for the people concerned. This was done as described in the paragraphs mentioned above; and even when the patient tried hard to wriggle out of it, the therapist remained adamant and stood his ground.

SESSION 21 24 October 1961

Length of interval since last session: 4 days

A. INITIAL EXPECTATIONS

I expected some further work and about two sessions ago I even predicted a paranoidally intense period. To my surprise, the interview was very friendly and not intense at all.

B. ATMOSPHERE

His old self, very friendly, no sign of the high paranoid tension of the previous session.

C.&D. MAIN TRENDS

1. Reported all-round progress. After the last session no more questioning, no more discussion. He and Farah have enjoyed undisturbed peace. He even thought of two plans – either to take Farah away to Africa for a couple of weeks, or suggest to her that she should go to her sister for about a week or ten days to recover from the hardships of the last few weeks.
2. He now understands the situation. Everything has become clear and he accepts what was worked out among the three of us, etc. I interpreted here that it is tantamount to accepting the fact that he has won over his rival.
3. We then went over to his inferiority feelings, with respect both to men and women. (a) Father, Keith, James, and perhaps even myself. He accepted this and said that it is still rather curious for him to feel that he has superseded his father, and now he has to accept that he has superseded James. I was left out. (b) We recalled Keith's statement that Mr Baker always felt unacceptable to the various girls; he never felt that anyone could like him. He even mentioned in confirmation that Keith

always felt very sore about the fact that he, Keith, was much shorter than Mr Baker. All this had now fallen into place.

4. This was the tone of the session and the whole thing went on along these lines. He now felt happy again that he has got a good wife who, though not very demonstrative – in fact much less so than he himself – is undoubtedly a loving partner.

5. At the end of the session we agreed that I should see him next Friday, and then once a week, to tail off before I go to America.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

I felt that the flatness ought to have been interpreted, but I have no idea how.

F. FOCAL AIMS

Unchanged.

G. OUTCOME

Rather puzzling. I don't know what to think of it.

COMMENTS ON SESSION 21

C&D 2. This is another example of 'selective attention' and 'selective neglect'. The patient's associations are interpreted so that the work should be brought back to one of the foci selected.

As a consequence, as paragraph 3 shows, Mr Baker was able to work hard in the chosen focal area and make some considerable progress towards getting to a solution.

In paragraph 4 a new topic was introduced, namely, that his wife was less demonstrative than he himself. This may, of course, be the result of her upbringing – she is an Oriental woman and is supposed to wait for her husband to approach her – but this may also be further evidence for his paranoid suspicion, namely, that she is still in love with James although she married Mr Baker. For the time being, this was left untouched. We don't know why the therapist did not include a reference under Section E of his report.

SESSION 22 27 October 1961
Length of interval since last session: 3 days

A. INITIAL EXPECTATIONS

Uncertain but not hopeless.

B. ATMOSPHERE

Usual. Friendly.

C.&D. MAIN TRENDS

1. Continued improvement, no more questioning, relaxed and pleasant atmosphere at home. Farah asked him to tell me that according to her Mr Baker is much more relaxed; even when he comes tired from the works, he is only ordinarily tired.

Some talk about what might have caused the change. Gradually it emerged, and it was put into words by me, that the main cause was that we two understood each other.

2. He then went back to his rumination about Farah 'pretending' (a) to him that she had never had any doubt that she loved him; and (b) to James that she was in love with him and agreed to call him 'darling'. Again a long rumination followed which was stopped by my pointing out that it would be impossible to get a proper answer to his problems from outside. The problem we have to solve is 'what is he after', 'what has he got under his skin'.

3. After some hestitation, he accepted this but tried on several occasions to go back to his ruminations. He then added that perhaps the real trouble was his fear of loneliness.

4. I tried to bring out the similarity in the structure of the various situations to which we had to return time and again. In the traumatic situation there was a man, James, and a women, Farah, who were together to his (Mr Baker's) detriment. Here in the treatment a man, me, and a woman, Farah, are together to help him and this has a good effect on him. Perhaps the reason why the situation in Cyprus became so traumatic to him that it repeated a long-drawn-out situation in his childhood when father (a man) and mother (a woman) were together against him. He stopped for quite a while, and then added that something must be true in it as he vividly remembers that when he was about sixteen his mother said that the only thing she could do would be to divorce father. He jumped at this idea, convinced that it would be

marvellous if it happened, but mother, naturally, completely forgot about it immediately.

5. We then summed up that what he has to avoid at any cost is to be trapped into being forced to obey commands without resistance. That is what happened with father, and he is still smarting under it. Possibly he identifies himself with Farah who, because of her emotional entanglement with James, was trapped and forced into following James's suggestion to call him 'darling'.

This was the end of the session and he seemed considerably relieved.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

None.

F. FOCAL AIM

Roughly maintained but apparently a new one begins to emerge -- his identification with Farah when she was flirting with the other man. Possibly this might be the beginning of some work with his sublimated homosexuality. Needs to be watched.

G. OUTCOME

Promising. I will see him again next Friday.

COMMENTS ON SESSION 22

C&D 2 contains a fairly good example of what we mean by being ahead of the patient and giving a profound interpretation, in this case in the form of a question. In his attempt to get further material about Mr Baker's incessant questioning of his wife, the therapist said almost verbatim that the two of them had to find out 'what Mr Baker is after' and 'what he has got under his skin'. Although this is quite a sensible attempt and perhaps also timely, Mr Baker could not work with it and could not respond to it. He eventually tried to change the subject to a different topic. This we consider as a convincing proof that this sort of interpretation must be accepted as useless, at any rate for that particular moment.

Remarkably, he was able, as shown in paragraph 4, to accept a full interpretation, a mutative one in the strictest sense, that tried to

highlight the similarities in three situations, each consisting of a triangle, a man, a woman, and himself. The man and woman were: father and mother in his childhood; James and Farah in Cyprus; Farah and the therapist currently. This was accepted. He could work with it, and considerable progress was made that almost certainly could not have been made without this interpretation.

We have to ask ourselves what the essential difference is between the interpretation in paragraph 4 and that in paragraph 2. One possible explanation might be that in paragraph 2 the interpretation attempts to turn Mr Baker's attention away from the relationship with his objects and onto himself, in particular to some painful places in his internal world, while the interpretation in paragraph 4 brings together three situations, all full of conflict, which have already been discussed on several occasions but not in conjunction with each other. Whether this explanation is satisfactory or not, we would like to leave undecided.

SESSION 23 3 November 1961

Length of interval since last session: 7 days

A. INITIAL EXPECTATIONS

Not very much.

B. ATMOSPHERE

Usual friendly, but there were short periods when he was obviously under heavy strain. However, he recovered quickly and the session went on.

C.&D. MAIN TRENDS

(As I could not dictate the write-up immediately after the session and the session itself was rather complex, this report is of lower standard than usual.)

He first read out the notes that he made on Thursday afternoon when he felt very tired and went to bed. For a few days Farah's sister was staying with them at his own invitation. This meant that he had much less of Farah. Still, on Thursday afternoon he sent the two women off shopping while he went to bed and wrote the notes. After

reading them, he handed them to me. What follows is a verbatim transcript of the original:

'Pattern: feeling of fear and sense of loss or being alone and unloved. Onset: constant ache or pain in pit of stomach, coupled with feeling of apprehension. Usually this pain and feeling comes on after 15 to 30 minutes after awaking in morning. When this pain is absent, I feel much less worried by symptoms and thoughts.

I begin to feel that my obsession and questioning has been an attempt to rationalize this sense of apprehension and fear.

My real wish and desire was and has been to establish that Farah was not involved emotionally.

If I was able to feel this, then I felt completely secure – for a period – until such time as my reason and logic reasserted itself and said she was involved at a time. Then, in trying to accept this, the fear and apprehension returned and again the same routine of denial was indulged in – in an attempt to escape. I feel that some early childhood or adolescent event has predisposed me to this tendency. My love and security eventually reposed in Farah – this made me very happy – but I was still in fear of losing it, and my attempt to camouflage the event of Farah's conflict of emotions, was a conscious effort on my part to escape from my own conflict.

The following are some of the events in the past that have put me in panic:

Lack of mail
Wanting always to be mostly on my own with her
Compliments or attention from obvious admirers
Attention or interest shown in the opposite sex – but controlled by me
Lack of prowess as a dancer or lack of social attainment
Conversations in French resulting in sense of being left out of things
Fear when Farah was pregnant – afraid of losing her
Fear of accident in car as result of passing test
Dislike of entry into hospital
Afraid of dreams showing Farah in situations not favourable to me
Fear of palmistry or fortune-telling
Fear of Farah dying and being left alone

Situation in films, plays, or books, or life showing similarly very distasteful and unpleasant events
Many other situations too numerous to detail
Panic at being told never was in love.

Possible reasons for this (Recent talk with my GP)

Mother implied when she was young that the thought and fact of third child during war was not welcome. Reference to my not being breastfed.

Very serious illness of Mother at age of approximately 8/9 years. Recollections that I did not understand gravity of same – sent to stay with friends.

Again, serious illness at approximate age of 12 years (Mother's illness). Vague recollection of praying and praying – period seems vague and painful.

At this period remember preoccupation with meaning of death – always wondering about myself when parents died – especially Mother.

Symbols magic – after completion of rituals felt better and less apprehensive.

Sudden terror in lounge at early age – everything receding and staring at things which appeared to get smaller and smaller.

Childish fear of dark.

Very early memory of panic when taken for walk by Father's Secretary – she dressed in transparent mackintosh.

Fear during first childhood operation.

Nightmares during fevers – impossible task of counting.

Sense of misery during first term at school, unable to say so. Dreams and revulsions.

Cruelty or torture.

Dreams of creeping things, crabs or scorpion – anything that has pincers or stings.

Note: When recently said I was leaving, to find out feelings, so pleased when told this is not what was wanted and wanted me to stay.'[4]

[4] This is somewhat obscure, we think: it was he who wanted to leave and Farah who told him 'this is not wanted'.

After finishing, he read out a kind of dialogue between his wife and himself with the following notes:

'F. I told him (GP) I'd never been in love with you.
K. And what about J.?
F. I loved him very much.
K. And how do you know that?
F. Because I took the lead. I went after him. You see, he didn't lead. I went after him. But with you, you were always there – I followed – you didn't make me come after you.'

'The remarks above were made in relation to your conversation with GP, and they implied very strongly that this was what you meant, particularly when talking to him. But now you say, "Oh no, I meant I suppose I'd never loved anybody really". But when you came from GP – you said all this quite coolly and didn't seem the least surprised I should ask. You appeared to give the idea that *this was* the truth you wanted to give to me and that it should be obvious. If you told GP what you say you did – you know perfectly well my trouble was not that you *didn't* love me but that you *did* love someone else realizing it too late – and had let me TRAP you – or worse still had made you kid yourself other virtues were more important than love. I don't want details or questions, but for Heaven's Sake don't treat me as a Moron and say "I didn't know what I was saying". You were jolly cool and collected. Either you *know* you loved me or you *know* you didn't – it's as simple as *that* – but if you didn't – there must have been *something* very necessary and important to you that I could provide that you counted of greater importance.'

'What has happened once may happen again? Why can't I accept or believe? Was I afraid it would happen again?'

I am unable to recall what else went on in this session so I desist from letting my fantasy run free.

E. & F. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN, AND FOCAL AIM

No comment.

G. OUTCOME

It was obvious that he was greatly relieved by the session and I expect further improvement.

COMMENTS ON SESSION 23

Although they shouldn't, sessions like this do occur, which fact we feel should not be hidden or obfuscated here. In some sessions so much happens that it is very difficult to keep count. In others, the therapist may be so preoccupied with other events that he simply cannot reliably recall what has happened. This preoccupation may mean that he is overworked and so can't find time either immediately or the same day to dictate his report, or alternatively that his mind is tied up with events other than those that happened during the session, and of course this does impair both his perceptions and his recall. All of this happened with regard to Session 23. Apart from recording Mr Baker's notes, the therapist refrained from taking part so that at any rate he should not contaminate the clinical material with his own private affairs.

In addition, what has been said already, in the comments to Session 17, ought to be repeated. We mean the differential diagnosis between the two possibilities, paranoia as an irresistibly progressing process, and paranoia as a severe illness but still accessible to psychotherapeutic influences. Mr Baker's notes allow us a glimpse at the full intensity of the conflicting and complexly interwoven emotions in his internal life causing so much pain, suffering, and torment both to his wife and to himself. Although the therapist tried to remain steadfast, he could not escape completely from the emotional impact of this almost unbearable turmoil. The scientific expression of this impact was the reinforcement of his doubts about the differential diagnosis: should the fact that Mr Baker was able to express as clearly and directly as he did what was beneath his paranoid symptomatology be taken as a promising sign indicating that in spite of everything the therapeutic relationship was reliably strong? Or, on the contrary, should it be seen as a warning that the pathological processes will prove so strong as to be beyond influence? In spite of the exacerbation of this dilemma, the therapist decided to carry on with the treatment.

SESSION 24 9 November 1961
Length of interval since last session: 6 days

A. INITIAL EXPECTATIONS

Further easing.

B. ATMOSPHERE

Friendly and relaxed.

C.&D. MAIN TRENDS

1. Had the best week for about three years. No wish to ruminate or to question, but he was 'thrown' last night and since then has been worried and depressed. He went out last night with his friend, Keith, who told him that on one of his last visits to Mr Baker's house, Farah had broken down in the kitchen and told him (Keith) that she had to tell lies to her husband. This again started all his doubts and sufferings.

2. I wanted to stop this unfruitful rumination and pointed out that irrelevant remarks or happenings take on overwhelming importance for him if they come from the right direction, as if there were smouldering embers in him that can be fanned into flames by any wind. He accepted this and recalled a number of events like trains being late, Farah not communicating with him at the time agreed, etc., when he immediately jumps to the absolutely convincing conclusion that things are against him. I went on to say that he is convinced that fate is hostile to him in general, and in particular if he discovers that two people have anything to do with each other to his exclusion, he feels that there is a conspiracy against him. His answer was 'Dead right'. I used this opportunity to point out that apparently by some miracle I have succeeded in keeping out of this shady conspiracy. He laughed and said, 'not entirely', because evidently when I reported to him the results of the second Rorschach test, he did not believe me; he was convinced that I had kept something hidden from him.

3. He then asked me what I thought the cause of this was. I reminded him of his alleged inferiority complex. He cannot believe that he is lovable enough. We then went over his relationship to Farah. More than sixteen years of living with her had not convinced him sufficiently that from now on he could have faith in her. He readily admitted that in every respect she has been loyal and loving to him; still in his heart this

is not yet proven and all his questioning is to find proof that his confidence is really unfounded.

4. He went back to his relationship with the other branch of Mr Baker's family, especially his cousin (who is several years older than he is) whom he simply could not meet in his younger years – his stomach turned over. He recalled that his uncle, the cousin's father, was so much in love with him that he proposed adopting him. Apparently his uncle was as bad to his family as Mr Baker's father was to his. Of course, the two brothers hated each other like hell.

He then asked me whether all this was instrumental in creating in him the feeling of inferiority, or was it some single traumatic incident? I pointed out that possibly a whole series of events laid the foundation, but there were a few among them which were traumatic.

5. We then discussed his two different relationships with men and women. He said with women he never felt certain that any of them, including Farah, could really love him; they might remain with him out of sympathy but never out of love and enjoyment. Towards men he is always certain that they are all better than he is; he can never be a real rival.

We agreed that the causes of this general attitude must be uncovered.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

Really none, but it may be that I was somewhat pusillanimous in pursuing the possible sublimated homosexual implications of his associations.

F. FOCAL AIM

For the time being the same, but possibly a new aim might emerge -- latent homosexuality.

G. OUTCOME

Pleased with good results and remission. Somewhat uncertain whether in the frame of focal therapy I will be able to follow him where he needs to be followed.

COMMENTS ON SESSION 24

This can be understood as some sunshine after the storm. Apart from the improvement in his external life, Mr Baker was able to work hard and fruitfully in the therapeutic situation. Starting with a remark by his friend, which re-started his obsessional ruminations, he was able to accept the interpretation that he is, so to speak, harbouring smouldering embers in himself that can be fanned into flames by the slightest wind, especially if it blows from the right direction. In a further step he accepted that fate in general he feels is hostile to him, especially if he discovers that two people have anything to do with each other to his exclusion. At this point the therapist pointed out that apparently he (the therapist) was an exception to this rule. Mr Baker replied in great amusement that this was not so and quoted a time when he felt that the therapist was hiding something from him. He then asked himself what the cause of this general attitude could be. The therapist reminded him of his so-called inferiority complex, which made him feel that women can't love him and that men are always unquestionably superior to him. This is why sixteen years of experience with his wife's loyalty could not convince him that he could trust her. He understood that all his questioning has also the aim of finding proof that his disbelief has been justified.

From then he spontaneously went over to his relationship to his father, who he felt was against him, and to his father's brother, who although hostile to his own children was most loving to Mr Baker. This is a clear example of splitting the object into a good and a bad one.

This led to an important discussion about the cause of his feelings of inferiority. Is it inborn, or the result of some single traumatic incident? He was then able to accept a compromise proposed by the therapist – that possibly a whole series of events laid the foundation for his feelings of inferiority, but there must have been a few among them that were really traumatic.

This was a handful, and although this happens in psychoanalysis and long-term psychoanalytic therapy it is rather a rare event that all this can be dealt with in one single session.

One further remark – the problem of sublimated homosexuality seems to appear time and again like a sort of ghost. It definitely haunts, but it seems that it cannot be explicitly caught. The question must be put: is it because of the patient or because of the therapist?

SESSIONS 25 and 26 17 and 24 November 1961
Length of interval since last session: 7 days and 7 days

A. INITIAL EXPECTATIONS

Nothing spectacular, but hoped that the work would develop gradually.

B. ATMOSPHERE

Very friendly indeed, and this atmosphere was maintained by contributions from both sides.

C.&D. MAIN TRENDS

On the whole the two sessions were characterized less by spectacular events than by Mr Baker's increasing ability to recognize trends and movements in his inner life, and a corresponding deepening of his insight.

He realizes now that it was an impossible task to try to understand Farah's emotional involvements on the basis of his own feelings. If Farah had exactly the same feeling as he, it would have meant that she would have been a man (a remarkable piece of insight). Equally impossible is it to try to make her define and describe her emotions in logical terms. Emotions are not amenable to logical discipline.

The next group of associations revolved around his inhibitions with women. He recalled several instances when women had made overtures to him, but he was so afraid that he had to run away. Similarly he had no difficulty when prostitutes masturbated him, but it was always a difficult decision to go to bed with them. This, he thinks, goes back to his childhood when he was always apprehensive about something happening to his genitals. He vividly remembers how he hated it when his mother playfully put her hand up his trouser legs, or when father said, putting him to bed, 'I will have it'. On the other hand, he is quite certain that he was not afraid at all when having homosexual play, for instance, with the engineer.

This led to his better understanding of why he was so upset by the news that Farah was interested in the other man. A man's attitude to a woman he loves is a mixture of protectiveness and a desire for violent possession. In his case the protectiveness was very great, but the desire for violent possession could not develop properly, and he sees now that his jealousy of James was because he was afraid that James, being less inhibited than he, would behave more daringly and could even have

taken possession of Farah; that was why he so anxiously inquired whether she allowed James to go further than she allowed him to go.

That was about the end of the second session, and we agreed that he should come on Friday 12 January at 12.15.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

None.

F. FOCAL AIM

Largely maintained, but there are more and more indications that perhaps it will have to be extended to include some working through of his latent homosexuality.

G. OUTCOME

Apparently a period of paranoid development has been stopped and largely undone. At present he is fairly well adjusted, but, of course, one does not know how long it will last.

COMMENTS ON SESSIONS 25 AND 26

It is not mentioned in the write-up that the long interval between Sessions 26 and 27 was caused by the therapist's absence on an extended lecture tour to the United States, over a period including the Christmas holiday. The material produced in Sessions 25 and 26 belongs to the category that one might call consolidation. No new topic was touched upon, but everything that the patient said meant either a deeper understanding of what had already been discussed or an establishing of reliable links between topics that until then had remained separated. In the write-up of these two sessions, even more so than hitherto, the patient's own words were used as far as possible. This ought to be borne in mind when the report is read.

The write-up shows how Mr Baker discovered for himself how his projections distorted his relationship with his wife. In this comment on the therapy, we take the liberty of using analytic jargon more freely. Mr Baker projected much of his feelings onto his wife and thus the only way available to him to understand her was to understand her as a man. The recognition that this was the result of projection meant that Farah now became understandable to him as a woman.

The same process occurred with regard to his demand for a watertight, logically correct description of all emotions. He now discovered that perhaps he could also understand his demand as a result of projection, on most occasions though by no means on all; that other people, Farah for example, could not be expected to be like him. He also discovered that his habitual sexual behaviour with both men and women was connected with his early experiences in childhood both with his father and with his mother.

Last, he also discovered the reasons why he was so upset when hearing about James. He realized now that 'a man's attitude to a woman he loves is a mixture of protectiveness and a desire for violent possession'. Because of his character, protectiveness towards Farah was very strong in him right from the start, but in his desire for violent possession he was greatly inhibited. This was one of the roots of his jealousy of James and led to his incessant questioning of what happened between Farah and James, and especially of what Farah felt about it. All this amounts to a real therapeutic achievement in the treatment of a paranoia.

This impressive development was achieved largely by the patient himself with no interpretations proper by the therapist, although of course he helped a bit here and there. In consequence, we scored C&D 2, 3, 4, and 5 as independent discoveries, exactly five in number (see Chapter 6).

SESSION 27 11 February 1962

Length of interval since last session: 7 weeks

A. INITIAL EXPECTATIONS

Uncertain, because of the long wait, but it is perhaps worth mentioning that I ended the last write-up by saying, 'Apparently a period of paranoid development has been stopped and largely undone'. This session seems to confirm this opinion.

C.&D. MAIN TRENDS

1. He had some difficulty in parking his car, and so I saw his wife, whom he had brought along, in the waiting-room for a few minutes. She looked much better, quite calm and rather pretty. She told me that

things had been much better since the last period of treatment. Then Mr Baker appeared and we continued the session in my room.

2. He confirmed his wife's report and stated that the improvement started when his wife told him that at the height of the flirtation with James she really fell out of love with him, but when Mr Baker reappeared in Cyprus after a few days together she fell in love with him again, and that settled the matter for her. I sensed some danger for the future and tried to demonstrate that this simple and clear sentence will very likely prove in the long run only part of the truth, or, using Mr Baker's usual accusation, as an attempt to hide other parts of the truth.

3. He remonstrated against this but soon remembered an instance when his wife in her despair slapped his face, whereupon he became very angry and slapped her back. He wanted to quote it as proof that even when he was very angry, he was still in love with her, but this could – though with great difficulty – be accepted as at least a diminution of his love, or as an instance of a quite special kind of love which allows the hurting of the love object.

4. He then recalled that his GP gave him some sleeping tablets that apparently helped considerably. When he takes them, he is much quieter during the day and can cope with his paranoid ideas. Another piece of advice given by his GP was that perhaps there was no need to go to the bottom of his problems, and we might stop his psychotherapy at this point. This appealed to him and he asked what my opinion was. I accepted this as a possibility but stressed the need not to make a point of honour out of the stopping and so I proposed that he should make up his mind what he wanted, but even then it should be agreed that if there were any need he could ask for help. He interjected that perhaps the best thing would be that in that case they should both come for help, to which I replied that this would not be what I would prefer, because this kind of joint discussion is not therapy, only discussion. He accepted this and then we agreed further that if the need arose, he should ask for help for himself, but if his wife needed help, she should go to another therapist. This was accepted by both of them.

5. At that point I asked him whether he would like to have a period with me alone. He eagerly accepted, and his wife left us. First he thanked me profusely for the help he and his wife had got from me. I insisted that my main concern was him alone, which he accepted, and he added that the devil got some help and understanding too. It soon transpired that the devil was his aggressiveness, especially against his

wife, and eventually he admitted that the devil was his sexual wishes. He talked about his escapades and with some reluctance went on to talk about his sexual freedom with his wife.

I pointed out to him that this could be expressed as follows: (a) that his wife put restrictions on him and was able to lift them only after receiving a wholesome shock; this pleased him immensely. Then I added: (b) that it meant also that he was not able to make his wife see that her restrictions were unsatisfactory to both of them, and that it needed several years of silly acting-out before they achieved this freedom. When I then posed the question which description, (a) or (b), was nearer the truth,[5] he saw the point, accepted it with considerable relief, and that was where we parted.

We agreed that about Easter or Whitsun he would drop me a line in any case to inform me how he was getting on.

B. ATMOSPHERE

The atmosphere at the beginning was rather strained, he was talking under stress and with great emphasis. As the session got on its way, the strain eased and in the end he was his old friendly self again.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

None. Afterwards many occur to one, but I do not think they need be enumerated here.

F. FOCAL AIM

Remarkably remaining the same. The two problems still occupying the centre of the stage were his inability to accept his victory over his male opponents, and his ambivalent wish to share his wife with a man.

G. OUTCOME

It is difficult to assess how much of his decision to interrupt treatment was influenced (a) by my absence in America and (b) by the advice of his GP. Unquestionably both played a considerable part, but I think that the assessment given in the previous session, that apparently a paranoid period had been stopped and its effects largely undone, was fairly true. It remains to be seen how long this improvement will last.

[5] Or, dotting the i's and crossing the t's: either (a) was Farah the cause of everything; or (b) had his internal conflicts and difficulties the lion's share in the causation of his illness?

COMMENTS ON SESSION 27

Here perhaps is the place where a few words ought to be said about the role of the patient's general practitioner in the treatment. At the beginning he was most helpful and did everything he could do to keep the treatment going. It should be added that he is an excellent doctor who is knowledgeable, most conscientious with his patients, and takes good care of them. He has been the Bakers' general practitioner for many years and, as happens quite often in rural communities, his family and the Bakers, in addition to the professional relationship, became good friends. This went so far that they called each other by their first names. His enthusiastic and wholehearted support for the treatment was badly jolted when the planned tailing-off (Sessions 14 to 16) did not materialize. On the contrary, Mr Baker's state deteriorated threateningly. Apparently the general practitioner gradually lost some of his confidence in the treatment and especially didn't like the fact that the therapist asked him to prescribe mild hypnotics for the patient. The reason for this policy was that in this way the possibility of the two therapies interfering with each other was considerably reduced. True, but this sort of policy is possible only if the understanding between general practitioner and psychotherapist is reliable enough. In the latter phases of this treatment, this was apparently not quite the case. The therapist must be criticized for not being alert to this possible risk.

It is clear from the session report that one of the motives for Mr Baker's asking to end the treatment was his general practitioner's influence, the other two being: (a) the therapist's absence for about six weeks in America; and (b) the focal aims having been nearly completely achieved. From the therapist's side, the situation was equally complex. He felt, as is clearly stated in his report, that he had done his job: 'Apparently a period of paranoid development has been stopped and its effects largely undone.' He was satisfied with the result and, on the other hand, felt somewhat apprehensive about continuing with the treatment. He felt that a possible opening of further areas of conflict in the patient's mind might transform the focal therapy into long-term psychotherapy or psychoanalysis.

It was in this dilemma that he accepted the general practitioner's and the patient's joint desire to stop, instead of working towards changing their minds. In addition both Mr Baker and his wife reported good

results of the treatment so far and expressed their appreciation for the help they had received. It was obvious that things were settling down with Mr Baker, but the process had not yet been completed. He again managed to arrange that his wife and the therapist should have some time alone with him (see the second focal aim), and, in addition, proposed that if necessary his wife should also have the right to consult the therapist. For obvious reasons, this could not be accepted. The therapist insisted that his first responsibility was to Mr Baker.

An important step forward was that Mr Baker could talk in front of his wife about hitting her back in anger, and after a considerable resistance could accept that it was quite a special kind of love that allowed the hurting of the person one loved.

Some more work was done on his aggressiveness and his 'desire for violent possession' of his woman.

REPORT OF PROJECTIVE TEST

NAME OF PATIENT: Mr Baker

AGE: 44 (Married)

DATE: 24 October 1960

PSYCHOLOGIST: Tested by a woman psychologist; reported jointly by her and the Chief Psychologist, a man.

TEST GIVEN: Rorschach

A. REFERRAL DETAILS

This patient was referred privately by a psychiatrist for Rorschach testing before the patient was referred to Dr Balint for a second opinion. Thus the test was reported originally to the psychiatrist before the workshop's involvement in the case. The present report is being made on the *14 April 1961* by the Chief Psychologist (a man), in collaboration with the psychologist (a woman) who tested the patient.

B. RELATIONSHIP DEVELOPED IN INTERVIEW

1. *How does patient see and deal with psychologist?* His behaviour was formal, polite, and deferential. He was keen to cooperate fully yet seemed to fear the psychologist's reaction to what would be revealed. He felt the test situation to be a dangerous one – an ordeal – and he

stood up to it well. He came with his wife, and it was noted that he behaved towards her in a superior, even humiliating way.

2. *How does psychologist see and deal with patient?* Accepted all that he gave in a supportive way. Became aware of his capacity to be cruel, and felt sympathetic towards his wife.

3. *Changes occurring* None.

C. MANIFEST FEATURES OF TEST RESPONSES

1. *Patient's approach to the task* Very fully involved in the test – keen to make good use of the interview – anxious about what would be revealed. He tried hard and did well.

2. *Type of response content* A profusion of responses (72) with marked concern with minute areas of the cards. An unusually high number of sexual percepts, also of sinister, threatening percepts.

3. *Unusual features* The high number of responses and the sexual preoccupation is unusual. as is the presence of 'nightmarish' percepts. Also his perception of isolated parts of people and animals, rather than whole images.

D. INTERPRETATIONS GIVEN

None.

E. CHARACTER STRUCTURE AND PSYCHOPATHOLOGY

1. *Dominant fantasies and defences* The dominant theme is his anxiety and uncertainty about potency. He is obsessed with sexuality and is anxious and doubtful about it. Right at the beginning of the test he shows this concern, giving as his second response 'female genitals', and as his third response 'I can see a question mark here'. His obsessional concern with sexuality has a very strong paranoid quality. He feels challenged and threatened by the woman, who unconsciously is felt as a powerful, phallic, dangerous person. There is a recurring phantasy of the combined male/female object – the vagina that contains a penis. In relationship with this image he feels defenceless and inadequate. Something of his feeling is shown in his response to Card 3, which is of two full-bosomed negro women with elongated necks and high-heeled shoes. They are putting 'some poor missionary' in a cooking-pot.

His method of defence against this paranoid anxiety is (a) an

obsessional attempt to get control of the situation, to so control the woman as to belittle her and make her safe and useless. (b) He cannot maintain for long the illusion that the woman is harmless, and so he resorts to violent, sadistic, ruthless attacks against her. At some moments in the test he is quite literally tearing the woman to pieces, a particular concern being to divest her of her phallic properties. The attack against the woman was seen quite clearly in his relation with the psychologist. After having been presented with a card that he found particularly horrifying, he remarked 'I hope my smoking doesn't upset you'. He returned to an anal attack in the next card – first of all saying that it just looked like an ink-blot and, after a little while, seeing 'a very painful haemorrhoid – sorry about that'. It would seem that ruthless attack is his main line of defence – to castrate the threatening phallic woman. There are indications that his attack is not only because he feels threatened by her, but because he envies what she has, and so has to destroy it. (c) There is a third defensive mechanism that has much more of an ominous quality to it, this is to retreat from relationships altogether and adopt a position of complete self-sufficiency. Responses of this kind are mainly of very poor form quality in the record, which suggest that this fantasy of omnipotence can only be achieved at the cost of a partial break with reality. That he does resort from time to time to this in the Rorschach is a disturbing feature.

Although his object-relationships in the main have a strikingly paranoid quality, also strongly indicated is a need for dependency and a longing for supportive contact with the secure good object. This is represented in the Rorschach in his response 'an anchor' and also in the many responses in which he made use of the texture of the cards, indicative of a need for contact and security. I would think that he is probably very concerned about the obsessional sadistic part of himself, and very much needs to establish secure loving relationships, and is probably capable of doing so.

The main bulk of the fantasies in the Rorschach concerned his relations with women. Where father-figures appear, it would seem that they are in the main good figures. It is perhaps important that the 'anchor' response comes on card 4 (the Father card), as if he is especially seeking support from a man. Yet he feels very challenged by masculine sexuality and so needs to attack men whenever they are felt as rivals.

2. *Level of problem* The dominant area of anxiety is that regarding

genital issues. He seeks for genital contact with a woman, though he is plagued by anxiety lest she should turn out to be dangerous and castrating – thus he must turn his attack against her. This situation is mirrored by an identical fantasy at the oral level, where the feeding mother, whom he seeks, is represented as the wolf who fed Romulus and Remus, but the same area of the blot is also seen as an animal crouching, about to leap. There is no doubt that he is a severely ill man, and that the disturbance in his object-relationships pervades all levels – however, the problem seems to have become focused on genital anxieties.

3. *Balance of liabilities and assets* He has many assets. The way that he dealt with the psychologist (a woman) showed courage, and his attacks upon her were tempered by concern. The record also shows a capacity to recover after disturbance, and it is important that on nearly all the cards, he ends with quite a good and moderately satisfying response. He is of good intelligence, although his use of this is variable, and his intellectual control is very much weakened when obsessional/paranoid anxieties intrude.

In contrast to his strengths, there are a number of signs in the record that he is emotionally in a precarious position and that he is threatened by break-throughs of irrationality (uncertainty about what is real and what is not, paranoid ideas), and also by a tendency to seek relief through a regressive retreat from the danger and hostility that he experiences in the world around him. On balance, I would say that at the time of testing, he was very markedly disturbed, with the risk of a swing to a paranoid/schizoid condition.

F. DIAGNOSTIC SUMMARY

A paranoid illness, being kept precariously under control through obsessional character defences.

G. POINTERS FOR FOCAL THERAPY

1. *Aims of the therapy* To explore with him his sexual anxieties in terms of his fears of attack by the woman, his envy of her sexuality, and his need to control and attack her as self-defence.

Possibly a secondary focus could be his terror of being left without support – his fear that he will lose his anchor and that he feels threatened by collapse.

2. *Limitations* I think the extent of his paranoia, and the depth and severity of his illness, represent extreme limitations. I would think also that it is very likely that more anxiety might be aroused in treatment than he could cope with, and that a crisis could easily develop.

3. *Transference situation expected to develop* With a man that he could lean on a positive transference might develop; when he realizes the therapist's potency his persecutory anxiety and his envy of other people's sexuality would lead him to cruel attacks upon the therapist.

4. *Prognosis and prediction* For a limited aim the prognosis seems good, for he has considerable strengths; however, for anything radical, I would judge the prognosis very poor, except through analysis.

COMMENTS ON THE RORSCHACH REPORT 24 October 1960

Already here some of Mr Baker's main character traits appear clearly: his wish to cooperate and to please, with keenness to do well and to impress. Contrary to the psychological findings, his anxious preoccupation with his potency was not prominent during the treatment. One possible explanation might be the difference between the test and the treatment setting. In the test setting he was faced with a woman, stimulating him with weird cards. In the treatment situation his partner was a man, whose chief aim was not to stimulate but to understand him; thus the situation did not arouse potency problems.

The humiliation and cruel attacks on the phallic woman as his main line of defence is the psychologist's interpretation. Clinical phenomena during the treatment, which could have been interpreted in this way, were observed on several occasions, but were not interpreted in this manner. The same was true regarding various anal features. The reason was that these would have led away from the focus chosen, therefore they were treated by selective neglect.

The ambivalent relationship to father-figures was observed, but in the therapy the therapist deliberately tried to remain within the confines of a 'good figure (anchor)'. This does not mean that the therapist tried at all to spare him any unpleasant experience in the therapy or was anxious to avoid any increase of anxiety in his patient, quite the contrary. But he was always aware that he must not hurt his

patient's feelings unnecessarily, and worded his interpretations accordingly.

On the basis of the experiences in the therapy we may say that the diagnostic summary of the psychologist was correct in every detail. Mr Baker, at the time of the test, was suffering from a 'paranoid illness, being kept precariously under control through obsessional character defences'.

On the other hand, the aims of therapy were, as proposed by the psychologist, practically absent in the treatment. A different focus was chosen and the therapy was run accordingly. In spite of the very severe clinical picture, the psychologist's foreboding that more anxiety would be aroused than the patient could cope with did not materialize. True, very severe anxiety was encountered, but in spite of it the treatment continued and eventually terminated. Regarding transference and prognosis, the psychologist erred on the pessimistic side.

PSYCHOLOGIST'S RE-TEST REPORT

DATE: 20 July 1961
Chief Psychologist
TEST GIVEN: Rorschach

A. REFERRAL DETAILS

Routine re-test; 4 weeks after last therapeutic session.

B. RELATIONSHIP DEVELOPED IN INTERVIEW

1. *How does patient see and deal with psychologist?* He saw me as someone potentially helpful who was going to do something useful. He cooperated fully and appeared keen to get involved in the procedure. He did not appear to see it, in any sense, as an ordeal or representing any danger for him. Nevertheless, there was a noticeable element of suspicion, an undercurrent, for the most part well concealed.

2. *How does psychologist see and deal with patient?* In contrast to the experience of the first psychologist, a woman, during the first test, I was not aware of a sadistic part of him. I saw him as a pleasant person and felt interested in the work with him.

C. MANIFEST FEATURES OF TEST RESPONSES

1. *Patient's approach to the task* Fully involved in it, apparently relaxed and free from anxiety. As before, he tried hard and did well.

2. *Type of response content* Many of the responses were very much the same as in the first record, though with marked and very important minor differences. The total number of responses is reduced from 72 to 39. Although concentration on minor details of the blot is still a feature of the record, it is less so than in the original test. There are far fewer sexual and sinister responses.

3. *Unusual features* Two of the cards he said looked like ink-blots, and four of them he remarked did not look like ink-blots. This is a curious feature that I think has some relation to his own statement of the benefit he has got from treatment which is that 'it is just a question of facing up to the facts – facing up to life'. In the re-test it seems that he was much more interested in the reality facts of his experience than in being swayed by fantasy.

D. INTERPRETATIONS GIVEN

None.

E. CHARACTER STRUCTURE AND PSYCHOPATHOLOGY

1. *Dominant fantasies and defences* (In this section I shall follow, as far as possible, the order of presentation of the findings given in the first test report, 14 April 1961.) The dominant theme of the record still concerns his feelings and his anxieties about potency, but with the important difference that feelings of confidence in his virility are much nearer to him, and he is less doubtful about his capacity to be potent in competition with other men. In the first test potency was symbolically represented in one card by a response, 'something that flies', but he went on to say that it is not seen in flight – it just *might* be capable of taking off. In the re-test exactly the same percept was given except that this time, he simply remarked that it was *'capable* of being airborne'. There is another very interesting change in his perception, this time on the last card. The part of the blot that was seen originally as a 'wishbone' is now seen as the 'seed that spins as it falls off a tree'. One definitely gets the feeling that procreative activity is now thought of less in terms of magical wish fulfilment, and more in terms of reality.

In the first test the assessment was made that much of the

unconscious fantasy concerned his fear and envy of the phallic woman. In the re-test the phallic woman is again very much in evidence, but this time is felt to be less frightening. In the first test he saw two negro women with elongated necks, high-heeled shoes, and other phallic qualities, and these women were sinister and frightening – 'putting some poor missionary in the cooking pot'. In the re-test almost the identical phallic women are seen this time without the sinister, frightening quality.

In the original test it was judged that his lines of defence were threefold:

(a) an attempt, in imagination, to control the woman and make her safe and useless. In the re-test there is still evidence of his need to be in control, but with the difference that now his attempts to control his anxiety are much more successful. This, I would think, represents an increase of effective ego-functioning.
(b) his turning against the woman with violent sadistic attacks. This is completely absent on the re-test record, in fact an opposite process is indicated. Whereas in the original test, he attacked the frightening woman to the extent of dismembering her in his unconscious fantasy, in the re-test this is quite absent. Having acknowledged the presence of the powerful woman, and having dealt with her quite realistically, he finished on that card by the remark, 'that disposes of that one as far as I feel'. He has, in fact, managed to 'dispose of' this frightening object, not through an unconscious, violent attack upon her, but through coming to terms with her. An interesting comparison of the two records is in his response to card 6, which originally was seen as a cut right through the middle of a piece of meat. In the re-test he saw, in this area, 'a cleavage mark' and went on to say 'last time the psychologist asked me if it looked like a piece of meat cleaved down the middle, and I said it did'. Here he was disowning the sadistic part of himself and has very neatly projected it on to the first psychologist.
(c) a retreat from human relationships to a position of self-sufficiency. This also is quite absent from the re-test.

The dependency need is still present in the record in very much the same way, although again the intensity here is reduced, e.g. the 'anchor' response appears again but the area of the blot given to it is much more limited, and the percept seems to have less emotional meaning for him. I remarked in the first test report that he was

frightened of the sadistic part of himself. I would say that the sadistic feelings are now much less in evidence, and he is much less frightened of them.

2. *Level of problem* Here again there is an interesting and quite marked change. This time the fantasy level seems to be entirely genital. In the first test the women on card 3 were identified as such mainly because of their breasts. He spoke of them as 'rather full bosomed'. In the re-test the same women are seen, but the reason they are identified as women is not so much because of their breasts as because of their long necks and high-heeled shoes. Other changes are the absence in the re-test of the remark about the wolf who suckled Romulus and Remus; also the cooking-pot is missing. In general, one can say that the references to orality, particularly sadistic orality, are now absent.

3. *Balance of liabilities and assets* I am going to approach this assessment through a comparison of the two psychograms. First, there is the new balance of determinants on the 'movement' side of the graph. In the second test the direction of the change is towards greater maturity. Changes in his way of using the shading qualities of the card indicate a slight increase in his capacity to master anxiety. There is considerably less use of the textural qualities of the cards, and normally this is taken as an index of dependency need, the change in re-test being towards less of a primitive dependency need. On the 'colour' side of the graph, there is no real change – suggesting that his capacity to involve his feelings in relationships with the real world is still very much the same (i.e. there is a lack of spontaneity here).

The percentage of responses that have an 'animal' content is less, suggesting a greater freedom in his approach to the re-test, probably because of lower anxiety. Although he does not see so many 'popular' responses as he did in the first test, he sees far fewer 'original' responses of poor quality – thus, on balance, his perception of the world is less idiosyncratic.

One of the changes I think most important is that, whereas in the first test the ratio of complete human and animal percepts to parts of humans and animals was 13:22, this ratio on re-test is 11:7. I would like to think that this indicates an increase of 'whole objects' relationships, and I would judge that it probably does have this significance, especially in conjunction with the absence, in the re-test, of the unconscious fantasy of tearing his objects to pieces.

The eleven sexual percepts of the first test have now been reduced to two, and the four sinister responses are reduced to one.

Thus it can be seen that all the way through the re-test the direction of change is in terms of increased personality assets. It is especially noteworthy that the clear indications in the original test of thought disorder, leading one to take a serious view of the psychiatric disturbances, are now quite absent. There is absolutely no suggestion in the re-test of any psychotic content, nor of any regressive mechanisms. He is now much more able to meet the challenge of life realistically.

F. DIAGNOSTIC SUMMARY

The diagnosis is the same – an underlying paranoid state of affairs being kept in control through obsessional character defences – one would most certainly now delete the word 'precariously'. His anxiety is reduced and his defences are more effective. One could not describe this state of affairs as being optimally healthy, but certainly it is workable.

G. SUMMARY OF CHANGES

As has been mentioned above, many of the responses in the two records are almost identical; the ingredients of the character structure are very much the same, but in many important respects the balance of factors is different. The main changes are:

1. persecutory anxiety particularly in connection with women is reduced;
2. surprisingly, there is now no evidence of any real intrusion of pre-genital anxieties;
3. the situation is no longer precarious, there being no suggestion of any likelihood of a swing over to a psychotic breakdown. One wonders, on the basis of the evidence from the re-test, whether the degree of psychiatric disturbance was not over-emphasized in the original report. On going back over the first test, I am quite convinced that the original assessment was justified and that he really was in danger of becoming seriously ill;
4. his defences against anxiety are still very much of the same quality, but are much more effective. Absent from the second record are the outbursts of sadistic fantasy;
5. one of the quite minor differences in the two tests is that in the re-test there is more use of technical names, particularly anatomical

ones, i.e. in the first test some women were seen with 'a couple of awful large knee-caps on each'. In the re-test exactly the same percept is given except that it is now 'the two ladies have got protruding patellas: is that the term?' There are one or two other instances of the same change. On card 10 in the original test he saw, 'two horrible little things – very nasty they are'. In the re-test exactly the same percept is given except that it is now the 'two things – I call them gremlins'. This is a very minor piece of evidence, but I do feel that it may give a pointer to the psychodynamics of the treatment experience in terms of his internalizing of a tutor and guide who understands things, who can give things their correct names, etc.;

6. the formal graph of the two records show a change in the direction of increased maturity;
7. in terms of the unconscious fantasies revealed by the tests, it appears that his unconscious uncertainty about his potency is reduced.

COMMENTS ON THE RE-TEST

On the whole, the results of the second psychological test agreed with the therapist's impressions. Internal pressure and anxiety are considerably reduced, although paranoid features are still present. In particular, women have become less persecutory and sinister. No real evidence of pre-genital material intruding into his day-to-day functioning.

An agreement of this kind between psychologist and psychotherapist, according to the experiences of the workshop, is a favourable sign. It means that the patient is capable of communicating to people; his communications are so little distorted, and their meaning is so little influenced by the developing object-relationship, as to enable two different people to interpret them in remarkably similar ways.

FIRST FOLLOW-UP LETTER 30 April 1962
(Interval since Session 27: 11 weeks)

Dear Dr Balint:

You will no doubt recollect that we arranged that I should write to you sometime near Easter to let you know how things have progressed.

I am happy to say that the improvement has been maintained. Naturally there are odd off days when one feels a little down, but these phases pass quickly and are quickly resolved. My confidence, trust and insight have been re-established by Farah's help and – in some measure I feel – my own desire and determination to stand back and see facts as facts, sometimes I wonder really what all the 'panic' was about, and really what a damn fool I was. It is a fact however that these illnesses do occur, and I will always remember your patience and help extended to both of us. Should I at any time feel that a chat is necessary I will not hesitate to come and see you – and in any case I will keep you informed at some future date.

My sincerest good wishes for your health and again my thanks which I express in all sincerity.

Keith Baker.

FOLLOW-UP REPORT (1)

SESSION 28 2 August 1962
Length of interval since last session: about 6 months

A. INITIAL EXPECTATIONS

I wrote to him before my holiday asking for his news. Instead of answering, he rang up and proposed a session, and mentioned that he would like to bring Farah with him.

I was somewhat surprised by this suggestion and did not know how to assess it. In spite of this, I felt fairly confident because he mentioned on the telephone that things were not too bad.

B. ATMOSPHERE

Very relaxed, hardly any sign of undercurrent tension. We started the interview with Farah present (for about ten minutes), and all three of us seemed to be quite confident that things were going in the right way.

C.&D. MAIN TRENDS

1. In the first period only Farah spoke, reporting that things were much better than last year. There was hardly any questioning. She could not give even an indication of the frequency because for many weeks there had been none whatsoever. On the other hand, when there is some external upset, there is a tendency in Mr Baker to revert to this habit. Even then, however, it lasts only one or two nights, and then nothing happens for quite a while.

On the other hand, the small questions, never amounting to a long discussion, happen fairly constantly whenever they are on their own.

The other thing she wanted to mention was that they have discussed the role that her father and her loyalty to her family played in her indecision while Mr Baker was in India. The facts were that James was living in Cyprus with his family and that marrying him would have meant staying with her family, not hurting her father, and, in addition, having a background if she needed help and support. Marrying Mr Baker meant going against her father's wishes and going to live in England with nobody to support her. Still, she decided for this latter solution. She was very appreciative of the results and, although the present situation was not so good as it was before the first breakdown (eight years ago), or in the interval between the first and the second breakdowns (two years ago), she was quite happy with it and confident that things would improve further. She then left us.

2. Mr Baker then took up the story and reported how important it was for him to discover that this divided loyalty in Farah between her love for him and her love for her father helped him to accept the fact that she was interested up to a point in James. This is now understood by him and does not hurt any more.

Further, he can now see that it is possible to love two people at the same time, although not with the same intensity. Until now he could only imagine love on the either/or basis: either exclusively one person or else no love for him at all. He sees now that this is a kind of childish theory, possibly coming from somewhere in his childhood, but he has no idea about its exact origins. I interpreted here that apparently he

could not accept that he won against James, but now he can accept that he won against the two men, James allied with Farah's father (aim to bring to light his longstanding conflict with his own father and its influence on the present conflict).

3. He agreed with great alacrity: this was exactly what he felt. He got a kick out of the idea that he had won against the two men. He then went on to discuss the various repercussions that this idea led to and how much better he feels now that he has understood what happened and could now accept it. Soon he started to talk about a remark that I made in the beginning of the treatment, namely, that he was merciless and ruthless (at that time he rather protested against it). Now he was able to accept it and even confirm it with various details of how angry he felt in India when he got the message about James and how this had rankled in him ever since; how he kept it under control for many years and how it exploded during his two breakdowns. After having understood Farah's dilemma, his anger largely disappeared and he feels much less need to 'grill' Farah with his questioning.

4. He then went on to talk about Farah's sister-in-law, that is, her brother's wife. He simply cannot stand her. He hates her whole-heartedly, possibly because he makes her partly responsible for everything that happened. She was picked up by her husband in Palestine, just before Mr Baker arrived in Cyprus. She was a most welcome new member of the family, especially to Farah's father. Of course, Farah felt her nose put out of joint, because she was the favourite until then. When Mr Baker had to go off to India, the situation for Farah became still worse because she had nobody who really loved her. That was one of the reasons why she looked around for another boy-friend.

5. He mentioned that his mother is now much worse. She had to be transferred to a mental nursing home because it was simply impossible to keep her at home. She is very aggressive, especially against her husband, who is very upset after each visit. Remarkably, the only member of the family who can understand her and with whom she is always willing to talk is Mr Baker himself. The father is of no importance any more. The two men are on very friendly terms, and the butterflies in Mr Baker's stomach which were so unpleasant have completely gone. I interpreted again that the fact that he can accept his victory led to a general easing of his anger and resentment, which apparently led to a more peaceful situation all round.

6. Here I got my surprise. After a very brief hesitation he said 'You know, I have been in bed with other women four or five times since we last met'. To my rather surprised reaction, he continued 'Not important women — kind of prostitutes'. He had got some fun out of it, not very much. Of course, he had told Farah what happened, she had accepted it, although not with great happiness. I interpreted that his anger against Farah had not completely abated. He still wants to hurt her and has chosen this way of doing so. Although Farah does not show any unfavourable reaction, he ought to be on his guard not to strain things too much. He saw this point and said that apparently he must recompense himself because of all the unhappiness that he had endured during his young years and the early years of his marriage. I added to it that this was quite understandable, but there is something else in it, namely, that he makes Farah pay for any compensation that he votes for himself.

7. He accepted this and, as the time was almost up, he just briefly mentioned that he does not very often use the sleeping pills that were prescribed by his general practitioner and which led to the friction between the general practitioner and me. He finds that if he takes the pills for one night, they have excellent results, but if he carries on with them, he feels rather wretched and miserable and very tired. I accepted this compliment and we quickly agreed that he can take them whenever he is very upset, but not as a regular standby.

8. Both of us expressed our hope that the improvement achieved will be maintained or even added to. Should any trouble occur, he will get in touch with me, especially if he cannot get the upper hand. In any case, he will write to me towards the end of the autumn, but, if not, I should drop him a line in December.

E. INTERPRETATIONS THOUGHT OF BUT NOT GIVEN

The two most important ones are: (a) the slight change in his latent homosexual attitude; he cannot accept the victory over one rival, but is willing to accept it over a rival plus a father-figure; (b) the other is about the transference; he has accepted me as his ally and helper, has introjected my ideas and words and finds them helpful. The reason why I refrained from giving these two interrelated interpretations was that they would have led the therapy away from its focal aim.

F. FOCAL AIM

I can only repeat what I said in the last session report, that it proved remarkably correct. What we achieved was to help him on the one hand accept his victory over his rival and on the other hand to share his wife up to a point with another man who in this case is a composite figure consisting partly of his wife's father and partly of me.

G. OUTCOME, AFTERTHOUGHTS, AND PREDICTIONS

A highly acceptable ending of a difficult treatment. Apparently what I thought in Sessions 26 and 27 was correct, namely, that the treatment helped him to put a stop to a paranoid period, undo its effects, and even add some preventive work so that the possibility of another paranoid attack should be diminished. On the other hand, there is no question that his paranoia is still active. For instance, he must go on questioning his wife – but the intensity of the questioning has considerably diminished. It is very likely that this diminution will continue, and next time the situation will be still easier.

This is the short-term forecast, say for one or two years, and it is very difficult to predict what might happen afterwards. To be optimistic, I would say that enough work has been done to prevent a serious paranoid breakdown. To be pessimistic, I would say that it is possible that a new attack will come in due course but that even then the good relationship and understanding established between us would perhaps enable us to stop it in a shorter period than the last one.

SECOND FOLLOW-UP LETTER 5 April 1963
(Interval since Session 27: 1 year 2 months)

Dear Dr Balint:

Thank you for your kind note to me. I do apologize for having kept you for so long waiting for news. I had hoped to make a special point of coming to see you and have been putting this off for various reasons, one of them being the death of my mother last October with all the appendant family upsets, which is very understandable – my poor mother, she suffered much, and this in turn was very trying and upsetting for my father and sister. However, time passes and heals.

For myself – so very, very much happier, more relaxed and a deal of examining myself for a change – facing facts and not being terrified by them. Farah so much closer – a renewal of sentiments and shared tolerance that at times in the past seemed to have so suddenly vanished for both of us. I think in a difficulty of this nature one welcomes the passage of time and each week, month, one looks back and feels the awareness of the sustained progress, and the emergence of a fresh attitude and an enthusiasm that is so refreshing. Farah is her own self again, and we are so confident in this happiness that I wanted to tell you and not write it.

You often advised me to take up again some sort of sport – I did in the late summer of last year. I have always been fond of the sea – so sailing, of the most energetic type, dinghy racing, was the choice – pressed to some considerable degree by one of my sons – so now the possession of a very fast new boat, great fun, if sometimes rather moist, is had, by all, including wife who seems to spend endless hours hanging saturated sailing clothes in the garden.

I may in a week or two be in town and perhaps will give you a call to see if it is convenient to pay you a visit – this will be the pleasure to me. All good wishes,

Sincerely yours,

Keith Baker.

COMMENTS ON LETTER OF 5 APRIL 1963
(Written 1 year 2 months after Session 27)

The most important part of the letter is that which shows Mr Baker's changed mental attitude. He can now face facts and not be terrified by his fantasies projected into them. The improvement is maintained in spite of the sad fact that during this period he lost his mother. His change to more mature feelings towards both his mother and father have withstood this shock.

The important additional change is that he took up sailing in a highly competitive form in the company of his son. An interesting point is that Farah was made to care for both grand sailors by spending 'endless hours hanging saturated sailing clothes in the garden'.

In the triangle, father-son-woman, he could find a satisfactory solution and accept his victory – which he could not accept in the triangle, James-himself-Farah.

THIRD FOLLOW-UP LETTER 14 April 1965
(Written 3 years 2 months after Session 27)

Dear Dr Balint:

Thank you very much for your letter received this morning. It really is surprising how quickly time passes, it must be almost three years since we last met.

I do apologize for the apparent lapse in my contacting you either personally or by letter – but I imagined that my family physician would possibly send in a 'progress report' occasionally. The term 'progress' is most apt, Doctor, in this case. There is no doubt that our sessions were of the utmost value to me, and resulted in my taking a jolly good look at myself, and seeing life and relationships broadly, instead of peering through the telescope of one's mind and perceiving an enlarged view, sometimes also distorted.

On looking back over the years I realize, of course, that early upbringing, environment, and experiences, also lack of it, played its part in this distressing breakdown. How fortunate is the man who had the good fortune to receive the help, sympathy and understanding and, above all, the patience and affection from one's friends, particularly one's wife, and from yourself. I will not forget your patience (what a stubborn patient I must have been at times), but you knew I did feel that all this difficulty would eventually resolve itself.

I do apologize for the length of this letter, a short hurried note would not suffice to give you the overall picture. Farah and I are very happy and should these past difficulties ever be casually referred to, which is extremely seldom, it is without resentment, and if referred to, is not the main point of that particular conversation in any case.

As to general health, all good – I have taken up golf again, and despite my hand injury some years ago, which stopped my activities in this respect, can still break the 100 mark.

The sailing season starts this Easter, but the weather is too cold at the moment, last year had several successful races crewing for my son.

Business has been good – lots of hard work, a redevelopment plan has just been completed at the works, only to be followed by a rather serious outbreak of fire on the part of the plant last weekend, this is a setback as far as production is concerned, but we will surmount this sway in due course.

Doctor, how are you? Your wife and family and yourself we hope are all well. My best wishes for an enjoyable vacation. I fairly frequently visit London and during one of these visits will chance ringing you or your secretary, and perhaps we could arrange to meet again, which I would enjoy.

With kind regards from my wife and me,

Sincerely,

Keith Baker.

COMMENTS ON THE THIRD FOLLOW-UP LETTER

14 April 1965

(Written 3 years 2 months after Session 27)

The process of gaining insight and being influenced by this gain in his actions has apparently continued unabated. Mr Baker can now look at his old and recent past with critical eyes, and see the causal motivations behind them, but also how unrealistically he behaved and how much trouble and disturbance he caused both to himself and to the people he loved.

He reports that overall improvement continues. A special point is to be made about his realistic ability to compete with men. He could win sailing races without any subsequent trouble and, further, he was able to tolerate and even to enjoy that his son was the captain and he (Mr Baker) only the crew.

FOLLOW-UP REPORT (2)

SESSION 29 25 November 1966
Length of interval since last session: 4 years 3 months

A. INITIAL EXPECTATIONS

I wrote to him on the 13 November, asking him to contact me and come, if possible, for an interview. He rang up my secretary telling her that he was to come to London on the 24 and 25 November and asked for a time for an interview. This was exactly what I expected from him, provided things have remained as well as they were when I saw him last.

B. ATMOSPHERE

Very friendly, somewhat chummy, and for a very exacting observer, with a touch of hypomania.

C.&D. MAIN TRENDS

1. He started by confirming the story that he had already told my secretary that soon after my previous letter, written in April 1965, the works burned down almost completely, that this was the reason why he could not come then. Fortunately, he had fairly detailed plans prepared for an ideal lay-out in case they wanted to rebuild the works, so that reconditioning could be started immediately. It took them about nine months to rebuild the works, which is now almost completely automated and the whole operation can be run with a much reduced staff. This is a great source of pride for him. Then he talked in some detail about a new venture, which was entirely based on his ideas. He and his two brothers own one-third each of this new company, which is getting on very well, and he has great hopes that it will soon be working full steam.
2. Then he went on to report about his family. John, his oldest son, 21, is now in the City in a great shipping concern with very good prospects for the future. The young man is looking forward to spending the next year perhaps in France, then six months in Scandinavia and so on, seeing the world. Mr Baker hopes, however, that when the boy is twenty-five or twenty-six, he will consider joining the board of the family business because, of the younger generation, he is the only one who could do it. If this happens, Mr Baker would like gradually to hand over the management to him and looks forward to becoming a kind of

consulting chairman like his father now, well in his eighties and still getting a good salary.

His daughter, Mira, is 19 and is at Grenoble, having a magnificent time polishing up her French and getting a degree in French.

His younger son, Clive, is still at school and doing very well indeed.

He reported about the death of his mother and mentioned that his father and his sister have just moved to a larger house and are getting on quite well.

3. Farah, his wife, is feeling grand, no trouble whatsoever. They are very happy with each other. He does not feel any urge to question her. All this has either faded out or completely dropped away from him. Farah went to America for about two months last year to visit her relatives there and is preparing for another visit next year.

4. Then he talked about his various sporting activities. He is a keen golfer, his favourite partner is the other Keith who played an important part during his treatment. They are about equal and there is always great competition between them. He still has his sailing boat but hardly used it this year because John was not available, having to work in the City. He is somewhat afraid of it because the boat is a kind of racing craft, very fast, and in consequence somewhat unstable. John capsized with it a few times but got away. On one occasion Mr Baker took his wife out. They were about two miles out from shore when a very bad north squall hit them, and he had some difficulty in bringing her in. Since then he has hardly used the boat. The other Keith tried to persuade him to start skiing and he was seriously considering taking it up this winter. (On the whole, he gave the impression of being somewhat concerned with keeping up his present good physical condition, which is perhaps natural in a man of fifty.)

5. He then went back to talk about the treatment and its results. Used various characteristic phrases such as 'I had to mature, it was high time' and 'You, Dr Balint, started something very important and I was able to finish it. Now everything is peaceful' – all indicating the awareness of a process that took hold of him, changed direction under the influence of treatment, and could be ended by him, using insight and power gained during the treatment. It was an honest sharing of the praise; he gave me mine, but claimed his own quite frankly.

In addition, there were some hints of a slight tendency in him to projection or turning the tables. Time and again during the interview he turned the discussion around and started to make inquiries about my

age, my health, what happened to my son, is he still in America, whether Mrs Balint is all right, what my plans are for the future, etc. Although these were unmistakably present, they were not rigid at all and he could be brought back to the discussion of his problem without any difficulty.

6. Then a rather empty period followed when he gave his opinion about the labour and conservative governments, the British economy, etc. However, after a short while we came back to our relationship and he gave me the final compliment by saying how important it was for him to know that I was there in London and he could get in touch with me, should any need arise. He did not do so during the rather harassing period of the rebuilding of the works, but he knew that he could do it any time and this was a very good feeling. We parted on this note.

G. SUMMARY AND OUTCOME

As far as one can be certain on the basis of one interview, he is now a fairly effective businessman, who can use his knowledge and brain to get on in life, to overcome serious difficulties, and to cope with life in general. His family life seems to be fairly all right. The three children are developing well and with the promise of becoming adults without much upheaval. His relationship with his wife has reverted to the friendly, affectionate one that existed before his breakdown.

On the other hand, there are unmistakable signs of his interest in men and sports, but this too is not uncommon in the sort of businessman that he is. I mentioned above the slight tendency to projection, but I do not think that it can be considered as more than can be accepted as being within the normal limits. An especially favourable sign is that he can let his eldest son go away from him.

Although he misses the boy (see the story about sailing) and he hopes that he will return to the family business, he does not press him to do so; neither does he try to interfere with the boy's life.

Unquestionably, there is a marked homosexual tendency in him, but this is partly sublimated and partly controlled, and so does not interfere much either with his enjoyment of life or with his relationship with his wife. As regards the other component of the paranoid structure anal erotism – this too is present but he is fairly successful in sublimating it. The rest is almost certainly controlled. I think that he is rather precariously balanced, but the balance is unmistakably there, whereas it broke down five years ago. Moreover, as I said several times during the

treatment, and especially during the follow-up period, his relationship to me has been good enough to keep him going, on the one hand, and to enable him to look to me for further help, if necessary, on the other.

All in all, one can say that he has maintained the state in which the treatment was interrupted at the end of 1961, and in which I saw him for the last time in February, 1962. Considering that it is almost five years since this happened, one may say that the results seem to be fairly stable.

COMMENTS ON SESSION 29

Interval since Session 27: 4 years 9 months

There is only one point to add to the summary of the report. This is about Mr Baker's competitiveness with men, in this case with his two brothers. During the whole treatment Mr Baker talked a number of times about his discussions with his two brothers, who wanted the works to go on in its old way, while Mr Baker was very keen on modernization. In the end he decided to have all the plans prepared for the eventuality that he might win. In this session he reports that when a fire destroyed a large part of the works, he had everything ready for the modernization, which saved several months for the company.

EPILOGUE

This is the end of the follow-up proper. The contact between Mr Baker and the therapist has not stopped, but there is not much more to report. Mr Baker unexpectedly rang up the therapist in the autumn of 1967, not quite one year after Session 29, and asked whether he could drop in for a friendly chat, as he happened to be in London. The therapist had a free hour, Mr Baker appeared and they, in fact, had a friendly chat. Nothing important was discussed, except for Mr Baker reiterating that everything was all right with him and his wife.

Early in 1968 Mr Baker wanted to take out an insurance policy for a fairly large sum. The company, as usual, asked for a medical report from the general practitioner, and learning about Mr Baker's past illnesses wanted to have an increased premium.

In agreement with the general practitioner, Mr Baker got in touch with the therapist and asked him to give a specialist's report about him so that the company should drop its request for a loaded premium.

The therapist wrote on 1 March 1968 to the general practitioner as follows:

Dear Doctor:

Thank you for your letter of February 28 which I was expecting to receive after Mr Baker's telephone call and subsequent letter of February 27. I have not heard yet from the insurance company, and I am using the few days to ask you a few questions because this request puts me in an awkward situation.

The reasons for it are:

1. I saw Mr Baker about six months ago and formed the opinion that he was in a very good state. I have no direct evidence of this, except for his own word. You, as the family doctor, know the situation much better. I would be grateful if you would confirm that his attacks of exaggerated jealousy have completely disappeared and his marriage can be called normal. I assume the same will be true about his relationship to the other members of his family and about his attitudes in business.
2. During the whole of the treatment, I have never used the words 'paranoia' or 'paranoic', so I am somewhat apprehensive that brandishing words like these might come as a shock to him. Of course, if you have used these words in front of him, the situation would be completely different. Could I have your advice on this point?
3. How did the insurance company get this diagnosis? Was it Mr Baker himself who supplied it or did they extract it from the medical report that, doubtless, you have been asked to furnish? If the latter is the case, we must be very careful indeed. Because, if we do not give him an honest explanation about the reason why his premium has been so considerably loaded, we might play into the hands of his illness: people talking against him, behind his back, in order to harm him.

I hope that you will agree with me that this is a somewhat difficult situation and will be able to help me to cope with it so that any unnecessary risk will be averted.

Yours sincerely,

Michael Balint, MD

To this letter, the general practitioner replied on 4 March 1968 as follows:

Dear Dr Balint:

Thank you for your letter of 1 March with regard to Mr Baker.

I have not been required to treat Mr Baker in any way for the past few years, and because of social contacts which my wife and I have with the Bakers, I am in a position to know that he has been exceptionally well and that his relationship to both his marriage and his business has been normal.

The insurance company were given the diagnosis of 'paranoia' by me when I supplied them, on request, with the necessary information on Mr Baker's past medical health.

As far as Mr Baker is concerned, I have used only the term 'nervous breakdown' which I thought adequately met the needs of the situation.

I do feel that the substantial loading of his premium constitutes a harsh judgment on the part of the company in the light of his well-being, and I hope you will be able to help.

Yours sincerely,

[General Practitioner]

Eventually, on 6 May 1968, Mr Baker announced triumphantly in a letter to the therapist that his proposal had been accepted by another company as first-class life with normal premium, so there was no need of any intervention by the therapist.

If we take this as the end of the follow-up, its length is more than six years, but at the time of writing this epilogue, more than eight years after termination, all signs indicate that Mr Baker's improvement has not only remained stable but is still continuing.

CHAPTER 6

Style of Treatment: Interpretations and Independent Discoveries

It has been said many times that in order to make relevant observations the scientist must have at least a tentative theory which enables him: (a) to order his observations; and (b) to validate or refute his hypotheses. On the other hand, it has been stated time and again that the therapist shall endeavour to discover the whole psychoanalytic theory in all its details in every patient he takes on for treatment, and this discovery ought to happen with the help of, and within, the joint work with that patient. One of us (MB) was one of the guinea-pigs used for the development of the technique of supervision in the early twenties in Berlin. He remembers one of his supervisors, Max Eitingon, as saying: 'Every new patient must be treated as if he had come directly from Mars; and as no one has met a Martian, everything about each patient must be considered as utterly unknown.'

We shall try to disentangle, using the history of Mr Baker's treatment as our basis, how far each of these contradictory theoretical attitudes is correct. Of course, we are fully aware that our findings may not have general validity because they reflect the atmosphere of the treatment of one particular patient by one particular therapist. We think that, on the whole, we were more influenced in our findings by the therapist's individual style of technique, and only to a lesser extent by the patient's personality and pathology.

We shall use four scores: *CO* will mean that the interpretation was based exclusively or predominantly on current observations in the therapeutic situation. If, however, a considerable part of the interpretation was based on observations made in previous sessions and not in the present one, we scored the interpretation as *M* (mixed). (See below.) *P Psa K* will mean that the interpretation was based exclusively

This chapter was written jointly by Michael Balint and Paul H. Ornstein.

or predominantly on pre-existing psychoanalytic knowledge, which may in some cases mean only preconceived ideas, prejudices or unproven biases, hypotheses, or wishful thinking held by the therapist. *M* will mean that we could not decide between *CO* and *P Psa K*, because either both factors were present, or the basis for the interpretation could not be identified with certainty. In addition, *ID* will denote an independent discovery by the patient; true, the previous therapeutic work might have helped him towards this discovery, but the discovery was made by him and not verbalized explicitly by the therapist. It must be added that the criteria for scoring an interpretation as *CO* were more stringent than those for any other class; whenever we had any doubts the interpretation was scored as *M*. A few examples from Session 6 follow: C&D 1 was scored as *M*, C&D 2 and 3, paragraph 1, *CO*, C&D 3, paragraph 2, *ID*. The three interpretations in C&D 5 were scored *M*, interpretation in paragraph 6 as *CO*.

It will be seen from the examples just quoted that we used a rather broad definition for interpretation. We consider interpretation to be anything originating from the therapist that has either or both of the two intentions that follow:

(a) to make the unconscious conscious;
(b) to influence the patient's subsequent associations so that they should proceed in the direction thought profitable by the therapist.

To illustrate what we mean: the therapist's silence was never scored, although it may mean something like 'Go on, I think we are proceeding in the right direction'. On the other hand, when the therapist said or did anything that was intended to change the flow of associations away from their present direction, we scored it as an interpretation.

Changing the direction of associations may be likened to the function of points on the railroad track. If the points are activated one way, the train will go straight; if in the other way, the train must inevitably deviate to the right or left as the case may be. In this study, the first case was not scored at all, the second, when the aim was to divert the train, was scored as an interpretation.

A good illustration of this point is given in Session 15: C&D paragraph 1: Mr and Mrs Baker arrived, possibly on account of a slip of memory in Mrs Baker, an hour later than arranged. As the therapist fortunately happened to have the next hour free, he saw them right

away. We considered this as an interpretation based on current observation and scored it accordingly. Translated into words, what the therapist 'said' by his behaviour could run: 'In spite of your resistance, I think that you need therapy right now. Luckily I am free, so here I am to listen to you.'

Another example is given in the same session, C&D, last paragraph. Here Mr Baker asked the therapist, at the end of the session, to have a few words with his wife. Bearing in mind his second focal aim, the therapist agreed. This we also scored as an interpretation based on current observation. What he 'said' could be translated into words as: 'I see that you are much less worried than before about what might happen between your wife and me, which could cause you the anguish you so well know.'

We anticipate that the proposal to classify explicit verbal interpretations and important non-verbal responses to the patient's 'offers' or 'opening gambits' in the same category as 'interpretations' may create serious misgivings in some of our readers. We have three arguments that may help them to see our idea more clearly. One is drawn from physics: Newton discovered that the movement of an apple falling to the ground and of the moon circling round the earth can be better understood if both of them are considered as cases of falling, that is, as masses moving under the influence of gravitational forces. It is obvious that the apple is falling, but this is not so obvious in the case of the moon, which after all has remained at about the same distance from the earth for aeons of time. Thinking in a similar way Einstein was able to predict that rays of light passing close to the sun will 'fall', that is deviate from their straight direction. Classifying seemingly independent phenomena in the same category led to a more profound understanding of them and, also, to important advances in our general theories.

The second argument comes from biology: since Linnaeus each species has had a double name. For example, the scientific name of the Conger eel is Conger conger – this means that the genus may have the same name as a species belonging to it. The reason for this is historical. Conger eel was the species first recognized and described. When it was discovered that several other species belonged to the same genus, the generic name was retained and the *differentia specifica* was denoted by adding the name of the new species while the first described member of the genus retained its old name in a duplicated form. In our mind, this is the case with interpretation. This was the first form of therapeutic

intervention recognized and described, so it is advisable to retain it as the name for the whole 'genus'.

The third argument is a sort of compromise between our ideas and the resistance we assume in some of our readers. We now propose as a compromise to call everything that the therapist does or says with a therapeutic intention 'therapeutic interventions'. Some of them are expressed in words borrowed from conventional adult language. For them the traditional name 'interpretation' should be retained. Other interventions are expressed either in behavioural language or in the form of elucidations, confrontations, arrangements, agreements or disagreements with something the patient proposes, responses to his requests, etc. These ought to be called either non-verbal interventions or, if they are couched in words, 'verbal therapeutic interventions' as distinct from interpretations proper. These interventions should be translated in the therapist's mind into the language of interpretation as shown in the examples given. This has several advantages: (1) it brings out the underlying essential identity between the two classes of interventions; (2) it enables the therapist to scrutinize his so-called non-interpretative interventions in the same manner as he should his interpretations proper and to reject some of them as unsuitable before 'giving them'; and (3) in addition, this 'translation' has enormous advantages for teaching and supervision, because it trains the future therapist to think for himself and decide on the basis of his own translation whether his intended intervention will be adequate, appropriate, desirable, or not.

If this compromise is acceptable, then our statistics should have the heading: Therapeutic Interventions based on current observations, on pre-existing psychoanalytic knowledge, mixed, or independent discoveries by the patient, which means that in fact we have treated in the same way interpretations proper and all other therapeutic interventions.

Within the framework of this study, we would like to avoid getting involved in the defence of the theories underlying these propositions and the technical consequences that follow from them, but we thought we had to describe explicitly the principles we followed in the construction of the statistics that follow.

One example of how difficult it is to decide whether a certain event should be classified as an interpretation, a therapeutic intervention, or simply a more detailed recall by the patient of familiar symptomatology,

with a number of new details, is given in Session Report 23. The problem is simplified here because we can use the patient's own handwritten notes giving his point of view undisturbed. The place of interpretation is, of course, taken here by independent discoveries. We wish to record that we scored Mr Baker as having made five independent discoveries while we classified the rest as repeating familiar symptomatology with some new details. We wonder how many of our readers will agree with our scoring.

A further, somewhat vague boundary where any decision must of necessity be somewhat arbitrary is the frontier between independent discoveries and the patient arriving at some insight during a trend of free association or as a response to an interpretation by the therapist. Here our guiding principle was our impression of whether the specific piece of insight amounted to a discovery and had a fair element of independence. If both these elements were present we scored it as an *ID*. Otherwise we disregarded it. The last difficulty was the problem inherent in what we call multiphasic interpretations. By this we mean that the therapist gives a part interpretation, waits for the associations stimulated by it, and if he feels justified he gives a further part, waits again for the response, and, if appropriate, he might add a third or a fourth part. The problem is whether one should score the part interpretation of each phase separately, or the whole as one interpretation. We have decided to use the first alternative throughout this study. We may add that the first phase or phases of such multiphasic interpretations are called by other authors preparatory interpretations.

One last remark – our statistical survey is based entirely upon clinical phenomenology. Every interpretation or intervention was scored, whether it achieved any therapeutic effect or none whatsoever – or anything in between these two. We did not aim at examining the value and correctness of any therapeutic intervention; we only counted them on the basis of the definitions given above.

The figures in *Table 1* could be summed up as follows: more than half, exactly 53 per cent, of all the therapeutic interventions were based in this treatment exclusively or predominantly on current observations. Only 18 per cent were considered as having a mixed or uncertain basis. Only 2 per cent of all the interventions were based exclusively or predominantly on pre-existing psychoanalytic knowledge. On the other hand, the number of independent discoveries by the patient amounted

TABLE 1 THERAPEUTIC INTERVENTIONS

	Initial phase (Sessions 1-7) 7 Sessions	*Middle phase (Sessions 8-22) 15 Sessions*	*Terminal phase (Sessions 23-27) 5 Sessions*	*Total*	*%*
CO	14	42	8	64	53
M	12	7	3	22	18
P Psa K	–	–	2	2	2
Subtotal (by therapist)	26	49	13	88	73
ID (by patient)	2	17	13	32	26
Grand total	28	66	26	120	99
Interventions per session	4	4¼	5	–	–

M = mixed
CO = current observations
P Psa K = pre-existing psychoanalytic knowledge
ID = independent discovery

to 26 per cent. These proportions, we think, are good indices for the individual style of this therapist. Similar studies might form the basis for a clinical comparative study of therapeutic styles.

To show how we have scored *ID*, may we refer to Sessions 25 and 26, C&D,

First paragraph: No score.

Second paragraph, first part: *ID* because we considered the second part of this paragraph not as a new discovery but only as a specific instance of the discovery obtained in the first sentence.

The third paragraph was rather difficult to score. After a long discussion, we decided to score as one *ID* all the part discoveries relating to women, but scored as another *ID* his realization of the difference of his feelings with regard to men.

The fourth paragraph we scored as two separate independent discoveries. One was his realization that a relationship between a man and a woman 'is a mixture of protectiveness and desire for violent

possession'. All the other part discoveries were considered as elaborations of the above, but we scored as another independent discovery his recognition that his incessant questioning was an attempt to cope with his jealousy.

The average number of interventions per session is four and a quarter, of which roughly 53 per cent are *CO*'s and 26 per cent are *ID*'s.

In order to get a picture of how the proportions of the classes of interventions changed during the various periods of the treatment, we divided the latter into three phases. We used the emergence of independent discoveries by the patient in the treatment as an indication of the end of the initial phase. We decided to consider as the beginning of the middle phase Session 8, during which the patient made more than one independent discovery. The terminal phase, equally arbitrarily, was counted as starting with Session 23, when therapist and patient reverted to once-a-week frequency after a critical intense period had been dealt with.

Accepting these divisions, the table shows that in the initial phase about the same number of *CO* and *M* class of interpretations were given, while the number of independent discoveries by the patient was considerably less than 10 per cent of all the interpretations given by the therapist.

In the middle phase, six out of seven interpretations were based exclusively or predominantly on current observations, while the independent discoveries of the patient amounted roughly to one in four of all the therapeutic interventions.

In the terminal phase, the proportion between *CO* and *M* was about three to one while the number of *ID*'s was exactly the same as that of the interpretations made by the therapist.

We think that these figures illustrate the progress of the therapy and the rate of increasingly mature control and responsibility by the patient.

The number of interventions per session show a steady increase from the initial to the terminal phase. They were four in the initial phase, four and a quarter in the middle phase, and five in the terminal phase. However, as both the absolute figures and the changes are rather small we cannot claim statistical significance for them. In any case, the change was in the right direction.

CHAPTER 7

Mr Baker's Treatment Experience as a Process

In the preceding chapter we have examined some aspects of the therapeutic technique, namely, the style of treatment with reference to the kinds of interpretations given. We did this there in a descriptive fashion, aiming at a certain degree of generalization, so that a comparative evaluation of therapeutic techniques should in the future be made easier for us. What we had to omit in that chapter was a consideration of technique as it is embedded in and dictated by the process of treatment. This is what we intend to include in this chapter.

What is this process that has such a central role in psychotherapy? Without attempting to define it exhaustively here, we wish to refer back to Chapter 1 where we indicated that there were two aspects of this process we planned to examine: (1) the developing doctor–patient relationship; and (2) the interaction between the patient's associations and the therapist's choice of interventions. The first one describes the emotional, experiential side of this interaction. The second one describes the verbal and non-verbal responses of the therapist to what the patient 'offers' verbally or in his behaviour.

What is the relationship between these two levels of interaction? When patient and doctor meet and they embark on the joint venture of psychotherapy, the contribution of each will determine the emotional atmosphere between them and what they will talk about.

This atmosphere is characterized on the part of the patient by an attempt at experiencing in the present, or re-experiencing from the past, certain aspects of his unresolved problems and making them come out right this time, with the therapist as the replica of important figures in his own early life.

On the part of the doctor the atmosphere is characterized by allowing this experiencing or re-experiencing to occur, as much as is

This chapter was written by Paul Ornstein after Michael Balint's death.

necessary for the particular therapeutic task. The therapist's contribution to this atmosphere has to facilitate reflecting, remembering, linking up past with present, etc., so that the patient may find new solutions to his old problems. Another way to put this, as Balint has frequently done: the therapist has to *accept* what the patient offers. He then has to *understand* it. Finally, at the appropriate moment he will have to *interpret* it, so that the patient should also understand it. After all, the therapeutic process aims at bringing to this level of understanding whatever occurs on the level of emotions. What needs to be interpreted (how much, when, and for what purpose) depends, of course, on the goals of the treatment and its particular format. In focal psychotherapy, for example, of all that the patient offers only those aspects are interpreted that facilitate and enhance the work on the chosen focus.

It should be stressed that what has been described in the preceding paragraphs as 'experiencing' or 're-experiencing' in therapy is expressed by the patient in what he offers in *words* and in his *behaviour*. The therapeutic task then is to capture verbally and cognitively as much of what is offered as is necessary to attain the specific goals of the treatment. If this interpretative phase does not set in – if the patient is merely allowed his repetitive behaviour – this may go on endlessly, though it may afford the patient some direct satisfaction and relief, perhaps only temporarily or perhaps even on a longer-term basis, but without change in the direction of emotional maturation.

With this preamble we are ready to describe the two levels of interaction in the treatment of Mr Baker by Balint. However, instead of following them in detail, session by session, we will only give examples of a few significant interchanges and let the reader scrutinize the session reports in as great detail as he wishes in order to make a study of Balint's therapeutic thinking and technique.

A useful way of tuning in on the process is to examine the initial contribution of each participant and then follow the vicissitudes of the doctor–patient relationship and the unfolding of the interpretations as the 'red thread' of the therapeutic events. It is around this red thread that we can most easily organize our clinical and theoretical thinking as they relate to the various issues of the treatment.

The statement just made implies something about the process that is worth making explicit. In general terms the events in therapy have a continuity over time. They have a discernible direction and are related

to each other, i.e. one thing leads to another. At any point in this process various events can be related to preceding ones and those that follow can either be anticipated or be retrospectively linked up with each other.

Focal psychotherapy, in general, but the treatment in Chapter 5 in particular, lends itself rather well to a study of the therapeutic process. The explicitly stated focal aim helps the therapist (and should help the reader) to keep his eye on the red thread of the therapeutic process. The particular organization of the session reports also makes this task easier.

To aid us further in our presentation, we will abstract some representative samples from the following phases of this well-documented and unique treatment process: (a) the diagnostic and beginning phase; (b) the middle phase; and (c) the termination phase.

A. THE DIAGNOSTIC AND THE BEGINNING PHASE

Mr Baker was referred to Balint for possible psychotherapy as a last resort to avert hospitalization for a longstanding, severe, jealousy paranoia. This was well circumscribed and largely restricted to an increasing preoccupation with what his wife might have felt towards another man, James, who courted her before they were married some twenty years before. He questioned his wife incessantly, compulsively, and revengefully, about the details of her experiences with James and tortured her with his demands and accusations. He extracted statements from her, which she made only to pacify him but had to retract later on because they were untrue. Once he had trapped her in various contradictions, he would be infuriated at having been deceived and the questioning would start all over again.

Mr Baker gave a very good account of himself during the diagnostic interviews. He was eager to talk and wanted to sort out with the therapist what he could not sort out for himself with his wife. The therapist responded with a trial intervention (Session 1, F), saying that '. . . he needed somebody to act as a sounding-board. . . .'

At the end of the first interview, Mrs Baker was seen briefly at her own request, with Mr Baker's permission and in his presence. She confirmed what he presented. Before they departed, Mr Baker asked to be seen again as soon as possible.

During the second interview, one week later, the patient filled in some of the details of his background. He then said that he had often pondered, from the beginning of his marriage, what happened between his wife and his former rival, but this did not make him ill until the mid-1950s. In response to a question he related that he moved into a new house, his father-in-law (of whom he was very fond and who was especially fond of him) died, and he and his brothers acquired the majority interest in the family business from their father all at about the same time. He soon returned in the discussion to his preoccupation with his wife's relationship with James and elaborated upon the background within which his wife, Farah, turned to James, during an interval in their relationship caused by Mr Baker's posting to India.

He felt that since the first interview much had changed. He now knew all the facts, he and his wife finally understood each other, and everything had been cleared up. Yet he soon contradicted this by returning to his ruminations. The therapist responded by 'pointing out that for several years he had been able to bear this problem without much trouble, but something must have happened to him about six years ago, and again about eighteen months ago, that brought things to a head, and that perhaps if we could find out what these things meant to him, he might be in a better position to prevent a further breakdown' (Session 2, C&D). The patient did not like this and bypassed it by returning to his paranoid thoughts. The therapist went on anyhow to propose to investigate what happened in Mr Baker that led to his previous two breakdowns and thought that this might take between ten and twenty sessions. Mr Baker merely wanted to use the therapist as a sounding-board for a maximum of five or six sessions. He was to discuss this with the referring doctor and with his wife before he would reach a decision. He thanked the therapist warmly and profusely for what he had done – and was not heard from for fifteen weeks.

What sort of a diagnostic and beginning phase is this? What can be said about it in terms of the process that we wish to identify and follow?

Significantly, the doctor–patient relationship as characterized by the therapist (Session 1, E and Session 2, B) is most revealing. The patient seems to have found what he needed in the person of the therapist. The therapist, in turn, responded cautiously, but very positively to the patient's appeal. He also recognized the patient's latent homosexual feelings for him. From the atmosphere of the interview, it seemed that

patient and therapist 'hit if off', which resulted in a productive and clearcut diagnostic encounter. The therapist succeeded in facilitating the diagnostic process with a trial intervention (Session 1, F).

As a result of this first interview, the therapist anticipated an easing of tension and an increase in the patient's friendly, homosexual affection (Session 2, A), but the response was much more than that: there was an improvement in his relationship to his wife, he could sleep better, and he planned to return to work (Session 2, B1). The therapist, encouraged by the response, remained cautious, but began some interpretative work and proposed the terms for treatment, which the patient was not able to utilize (Session 2, B2 and C&D last 2 paragraphs).

By not accepting the patient's own proposal for treatment, the therapist may have interfered with some hope or expectation of the patient without which Mr Baker could not enter into psychotherapy. This was his need for a benign, loving, all-accepting father in the transference. This patient, in his precarious balance, may have experienced the therapist's intervention as an enormous demand for change from which he had to flee (see also Comments on Session 2).

In spite of this stalemate at the end of the second diagnostic interview, the work accomplished permitted the therapist to formulate rather precisely his focal aims. A glance at the 'therapeutic intervention thought of but not given' (Session 2, E) helps us appreciate on what basis the therapist chose these particular foci. In Session 2, F, and H(b) and (c), the therapist selected the patient's guilt feelings caused by his triumph over his homosexual rivals (James, his father-in-law, his own father) as his more ambitious aim. He thought that as a secondary aim, letting the patient share his wife with another man (symbolically, the therapist in the transference) might either be used as an entry into or accepted as the whole therapy, since Mr Baker appeared to settle for this aim only. (See also Comments on Session 2, paragraphs 3 and 4.)

After an interval of fourteen weeks, the patient returned for therapy. He did fairly well in the interim for a while; he worked throughout, but another episode of questioning his wife and her recantations made him realize how unbearable his nagging must have been to her, and the whole episode again shook his confidence in her veracity. Thus, he presented himself once more with his focal problem of an intense jealousy of James and of not being able to accept his victory over him (and his other homosexual rivals).

The question may be asked, what kind of a therapeutic experience did Mr Baker need in order to achieve either the more ambitious or the subsidiary aim? The two are, of course, closely related. If he could share, symbolically, his wife with his homosexual rivals, it would mean an easing of his morbid jealousy and of the relentless questioning of his wife. If he could accept his victory over his rivals, it would mean a deeper change in his inferiority feelings towards them, and he could also give up his homosexual interest in them, in the sense that he would not 'need to be on most amicable terms with every man who means anything in his life' (see Session 2, E).

What evidence is there that either of these two aims could be accomplished? Mr Baker showed during the third session 'great confidence and trust [in the therapist] which also has a very strong sublimated homosexual tinge' (Session 3, E). Thus, Mr Baker returned with his initial transference to the therapist intact or perhaps even more intensified. As long as he sustains this transference, which during the first fifteen or so sessions remains relatively 'low-key', though always palpably present and frequently interpreted, it will be possible for patient and therapist to pursue the focal aim.

In fact, this is what the therapist initiates in the third session, when he interprets Mr Baker's cruelty and ruthlessness towards his wife as his revenge for having been hurt by her. This leads into the 'pre-history' of hurt feelings – 'he was hurt by women because they rejected him and by men because they were so much better and superior'. (Session 3, C&D 3 and comments on Session 3, last paragraph.) As a result, the therapist anticipated some improvement and a deepening of the homosexual transference (Session 4, A and B).

Not only was there immediate improvement (Session 4, C&D 1), but the interpretative process of the previous session led Mr Baker to say 'that the reason he cannot accept the facts [as they relate to Farah's experiences with James] and have done with them must go back to his experiences in childhood and adolescence and especially in relation to his father' (Session 4, C&D 2). He then produced some highly revealing early memories and childhood recollections (Session 4, C&D 2, 3, 4, 5) full of embarrassing details involving various homosexual experiences that lasted up to about the age of twenty.

The therapist responded to all of this by saying: 'that the experiences of his childhood and adolescence created in him a feeling that he was not a proper man, that other men were superior to him, and that he had

to lose whenever he competed against anyone else, like father or the other officer, James' (Session 4, C&D 6).

The preceding sample is a good illustration of how the therapist works towards his focal aim and of the patient's ability to make use of the interpretations and respond with new and confirmatory recollections. In addition, here (Session 4, C&D 2), as so many times in this therapy, the therapist's style of interventions allowed the patient to make an 'independent discovery' (see Chapter 6). The sequence just presented is also an example of what we call the interpretative process (see also Structure of Session 9).

A review of Sessions 3, 4, and 5 will permit the reader to follow in detail the patient's associations, the therapist's interventions, the patient's responses to those interventions, the therapist's next intervention, and so on. It is instructive to see how this therapist does not lose sight of his focal aim, and as a result the various events in this treatment are meaningfully connected into a cohesive process. Where he vacillates regarding his focal aims, he makes it quite explicit. This too is helpful in following the treatment process. The therapist's remarks under Sections E and F in each session report illuminate the ongoing process and along with Section A hint at its subsequent direction.

We will not follow the treatment to its middle phase, except by stating that the presenting problem was more thoroughly understood step by step in its origins with Mr Baker's experiences while courting his fiancée, and with his winning her away from James. Some of the early childhood and later boyhood antecedents were meaningfully linked up in the therapeutic work by the seventh and eighth sessions. The therapist then thought that treatment could soon be terminated. His assessment was that considerable work was done on his more ambitious focal aim and he could terminate on a note of his subsidiary aim symbolically achieved (Session 7, F). However, further treatment became necessary, and this leads us to what we might now call the middle phase of treatment.

B. THE MIDDLE PHASE

Mr Baker continued to ruminate over the question of whether Farah was merely sexually excited by James, or loved him, or sought his companionship (Session 7, C&D 3). Each incident of rumination and recrimination was then brought into the treatment session and led to a

further understanding of his motives for the continued sadistic questioning of his wife (Session 8, C&D 2, 3, 4, 5). Whatever was understood about Mr Baker's relationship to his wife was then effectively connected, either by him or by the therapist, with his relationship to his father (Session 8, C&D 4 and 6). In that relationship it was Mr Baker who was sadistically treated, but at this point he was beginning to be able to stand up to the old man (Session 8, C&D 6) and also to be like him (Session 10, C&D 3). The interpretative work of this phase was sustained by a continuation of the homosexual father transference which was beautifully illustrated in a dream, 'in which a big snake, a very friendly creature, snuggled up to him and put his head in his lap. He was not afraid at all' (Session 9, C&D).

The fact that Mr Baker experienced the therapist as a friendly, big snake perhaps also allowed him to vent some of his anger and criticism, gently and indirectly, at him. The therapist was able to interpret that Mr Baker beat him with his ruminations as he did Farah (Session 12, C&D 4 and 5).

Patient and therapist were to use the ensuing six weeks interval (due to the therapist's holiday) following Session 13 as a test as to whether any further therapy was indicated.

In Session 14 Mr Baker reported continued improvement, a more self-assertive attitude, and an additional independent discovery: he realized that his constant questioning and tormenting were directed not only against his wife but also against himself for having taken Farah away from James (Session 14, C&D; see also Comments on Session 14).

Since everything was going well, the therapist suggested tailing off treatment. Mr Baker's next appointment was to be seven weeks later. It was also arranged to have him re-tested by the psychologist in the interim. The report confirmed the clinical findings.

While Mr Baker maintained his overall improvement, something new emerged, which was quite disturbing to Mrs Baker who was also present for part of Session 15. Mr Baker had picked up some prostitutes on several occasions and had himself masturbated by them and each time he had reported the whole affair to his wife. Reporting all the details he added that 'this meant a great liberation to him' (Session 15, C&D). The therapist commented that Mr Baker's liberation apparently had to be paid for by Mrs Baker's pains and the problem to be solved was: how much liberation at the price of how much suffering?

The details of Mr Baker's behaviour pin-pointed the fact (in addition

to a variety of other meanings, see Session 15, E) that he was doing to the prostitutes what his wife allowed James to do while Mr Baker was in India (Session 15, E 2). In addition, his way of responding to the suggested termination was to produce more alarming symptoms to draw the therapist's attention to himself (Session 15, E 3).

The therapist had no other choice but to accept Mr Baker's plea for more treatment (Comments on Session 15), and the middle phase was extended by further work on the original focal aims.

As a result of his 'acting-out', Mr Baker felt much relieved and closer to Farah. The therapist interpreted that perhaps this was due to the fact that he had paid her back for all the pain she caused him in Cyprus. He protested that there was a difference: Farah was emotionally involved with James, whereas he remained uninvolved with the prostitutes (Session 16, C&D 2).

In Session 16 there was evidence that Mr Baker was able to achieve much closer relationships to his mother, father, and Farah in direct response to his experiences in therapy (see Comments to Session 16). He wanted to end his treatment here and the therapist accepted this because he felt that Mr Baker could now accept his victory over his father, James, and other men (Session 16, F). Thus, another attempt at tailing off treatment was started.

About seven weeks later a more serious relapse brought Mr Baker back into therapy. He was 'near-psychotic, peremptory, unapproachable' (Session 17, C&D 2), which changed the atmosphere in treatment markedly for part of the session (Session 17, B).

Once the 'paranoid cloud' dissipated somewhat (Session 17, C&D 5 and 6) Mr Baker 'offered' his recent bout of tormenting his wife for further treatment. He was now desperately trying to ascertain whether Farah really loved James but married him for other reasons, and wanted to know point blank whether the therapist could help him and his wife not to torment each other any longer (Session 17, C&D 6).

The therapist, somewhat shaken by this most severe relapse (see Comments on Session 17, last paragraph), did offer more treatment since thus far every effort led to significant new understanding of the details of Mr Baker's focal problem. For the next three weeks patient and therapist met twice weekly (Sessions 17–22). The relapse was understood and interpreted as a revenge against the therapist at the threat of abandoning his patient. This seemed like a re-play of his revengeful tormenting of Farah for her threatened abandonment of him

in Cyprus when she turned to James. Earlier in this treatment (Session 9, C&D) Mr Baker talked about his 'utter loneliness' which meant to him that when he was in India, he felt that he was dropped, forgotten, and abandoned by someone important to him, namely Farah. This was now re-experienced in the transference and led to a tense, irritable, and paranoid atmosphere, as it did between Mr Baker and Farah, and earlier between Mr Baker and his father, thus leading therapeutically deeper into Mr Baker's current psychopathology (see Comments on Session 18).

The therapist interpreted that the same misunderstanding that leads to violent recrimination between Mr Baker and his wife might also have prevailed in therapy recently, leading to the current turmoil: 'we two did not understand each other and that was more than he [Mr Baker] could tolerate' (Session 18, C&D 3). This interpretation helped re-establish the previous friendly atmosphere in therapy and led Mr Baker to say that he needed a pat on the back by some man who was important to him, such as his friend Keith or the therapist. When he gets that pat on the back, things fall into shape and he feels much better (Session 19, C&D 6). Thus, Mr Baker's prevailing transference needs are well documented in his own words. It was this intense need that he hoped would be satisfied by the 'friendly snake' – therapist – and that hope sustained him in his therapeutic work (see also Comments on Session 19, last paragraph).

As a matter of fact, just two sessions later complete calm is restored both at home and within the sessions. Patient and therapist understood that this was achieved mainly because the two of them now understood each other again (Session 22, C&D 1). On the whole, the fact that the doctor–patient relationship could be re-established on a 'homosexual' friendship basis permitted the work on the focal issues to go on a bit further (Session 22, C&D 2, 3, 4, and 5). This work, its immediate results, and the therapist's anticipated trip to America, led to a final attempt at tailing off treatment.

C. THE TERMINATION PHASE

The various influences upon ending the treatment with Sessions 23 to 27 are discussed in Session 27, G and in the Comments on Session 27. This phase was ushered in by clear-cut symptomatic improvements and deepening of the understanding of Mr Baker's focal problems as a result of Sessions 17 to 22.

Mr Baker provided a very useful summary and an interesting document of his own understanding by bringing into Session 23 a list, summarizing his own problems as he now saw them and noting all events, past and present, that seem to have triggered off his fears, his sense of loss, loneliness, and feelings of being unloved – any or all of which could put him into a panic. He even went further and added a list of childhood antecedents and possible genetic roots that explain his difficulties (Session 22, C&D).

The termination phase of treatment, as it often does after a productive beginning and middle phase, not only consolidates what has been accomplished, but may still further deepen and extend the results. In this treatment process the therapist continued to maintain his focal aims and felt that a period of paranoid development had been stopped and its effects largely undone (Sessions 25 & 26, G; 27, G, and Comments on Session 27).

To gain further insight into his paranoid jealousy, Mr Baker was able to make use of the interpretation that whenever two people had anything to do with each other to his exclusion he felt that they conspired against him (Session 24, C&D 2). Though he has had no reason to mistrust Farah since they have been married, his constant questioning of her was aimed at finding proofs that his confidence in her was unfounded (Session 24, C&D 3). Beneath his mistrust was an 'inferiority complex' rooted in his feeling that women could never really love him and men were all better than he was (Session 24, C&D 5). This added one last bit to his understanding of his relentless questioning of what Farah felt for James. He said that 'a man's attitude to a woman he loves is a mixture of protectiveness and a desire for violent possession'. He was afraid that James would outdo him in the latter and could have taken possession of Farah while he was in India (Sessions 25 and 26, C&D).

Mr Baker chose to make Session 27 his last therapeutic session. Though the therapeutic process initiated and maintained at an unusual pace and intensity 'had not yet been completed' (see Comment on Session 27), the therapist accepted Mr Baker's decision.

Subsequent, detailed follow-up stretching over more than six years shows evidence that not only did Mr Baker maintain what he had achieved by Session 27, but that he was able to continue the process of attaining further improvement in many segments of his personal life: his relationship to his wife, children, his own parents, friends, and in his

business activities. Interestingly enough even during the first formal follow-up session (Session 28, C&D) the therapist was able to do some more work on his focal aims. The second formal follow-up session (Session 29, C&D) contains no interpretations.

The patient managed to leave the therapy retaining an image of the therapist as his ally and helper (Session 28, E), the positive part of his split father image.

What emerged in this therapeutic process can now be used to formulate the patient's psychopathology. This is what we intend to do in Chapter 8.

CHAPTER 8

Mr Baker's Personality and Illness

One would expect that it would not be a very difficult task to construct a fair picture of Mr Baker's personality and illness on the basis of what emerged during his treatment, and from the knowledge of the structure of the human personality that can be gained from the psychoanalytical and psychological literature. In what follows we intend to show that this task is anything but simple, even if one avoids, as we shall do, the intriguing problem of what constitutes the specific dynamic structure of jealousy paranoia.

Instead, we wish to focus upon Mr Baker's personality (or character) and the distortions of his personality (his illness or symptomatology) as these emerge for us from the diagnostic, therapeutic, and follow-up material presented in Chapter 5.

Before doing so, however, we must define our ideas about, and our ways of approaching, these two problem areas which traditionally are described as the patient's personality and symptomatology. Every patient presents himself always as a whole person, but never in any particular period in his entirety; only certain aspects of him will be observable and thus available for study at any one encounter with the therapist. Taking a series of encounters, the therapist will observe that certain aspects of the patient as a person have remained largely unchanged – these he subsumes under the heading 'personality' or 'character'; while he observes that others change under the impact of the therapeutic work – these he subsumes under the general heading of 'symptomatology'. We know that this method of differentiation between personality and symptomatology is based on a rough rule of thumb and not on reliable scientific propositions; still, fundamentally we classify our observations obtained during therapy on that basis.

Paul H. Ornstein made additions to this chapter after Michael Balint's death.

The usual way of by-passing this particular problem is to talk in a global fashion about the patient's psychopathology without differentiating the pathology of the personality from what is usually referred to as the clinical symptomatology.

Current thinking on this issue runs somewhat as follows: personality or character distorted leads to symptomatology. So these may be one and the same thing. The 'symptoms' are dynamic, economic, adaptive, and structural 'events' in the personality. Therapy rearranges these and thereby can also, sometimes, modify the underlying personality. This modification may not occur in terms of its 'basic structure' but only in terms of its 'trends' or 'tendencies'.

Thus, a further complication arises from the fact that certain parts of the personality or character do change during therapy. Our theory copes with this complication by calling these pathological personality or character traits. On the other hand, it is equally true that a number of treatments have to be terminated without certain symptoms being cured; that is, no, or very little, change can be observed in them. Here our theory uses phrases like 'this particular symptom has become characterologically anchored', 'has become egosyntonic', or even 'has become part of the ego-structure' etc.

Taking Mr Baker's case, we find it difficult to decide whether his 'anal-sadistic orientation' is a part of his symptomatology or of his personality. Our impression is that during treatment the intensity of his orientation has considerably diminished, but its direction remained unchanged. When we now ask what this observation means in theoretical terms we find ourselves in trouble: shall we say that by not being able to change this orientation the therapy was only a qualified success; or, on the other hand, that this orientation, being part of his personality, could not be expected to change fundamentally but only in its intensity? We could quote many other aspects of his case history which would present the same sort of dilemma.

Although we cannot resolve these problems satisfactorily, we have adopted as a working hypothesis the proposition that the features remaining unchanged during therapy should be considered as parts of the personality, while features changed by the therapy belong to the patient's symptomatology, and in what follows we shall discuss the observations made during the therapy under these two headings: the patient's personality; and the patient's psychopathology (or symptomatology or illness). Under the first, we shall subsume all his traits that

have not changed during the period of observation; under the second, those which changed under the impact of the therapy.

That this treatment developed in the way it did was determined not only by the technique used by the therapist, but also to a significant extent by Mr and Mrs Baker's personalities.

Taking Mr Baker first - it would be fair to describe him as almost a textbook case of what is called anal-sadistic character with all the composite formations of direct anal-sadistic trends and reaction formations against them. The history of his treatment amply demonstrates this.

Having said that, we would like to add that a further remarkable quality of his was his quiet but firm determination to see things through, no matter what mental effort and pain and anguish it cost him. His attitude throughout the treatment was that he was in dire trouble and, although entitled to and using every help available, it was *he* who had to do whatever was needed to get out of it. This does not mean that he was not obstinate (narrowminded) or resistant at times, but in spite of this he maintained throughout his basic attitude that it was also *his* responsibility to work hard.

The next important quality was his ability to preserve his trust in and love for his wife. True, he could at times be incredibly cruel to her, as one would expect in an anal-sadistic character, driving her almost to breaking-point. Yet, at the same time, there was never any question either in him or in her that he loved her.

Although this cannot be stated with the same certainty, everything that was observed about his wife tends to show that the same was true about her love for him. Even during the period of the most intense tormenting, when in her despair she went complaining either to the therapist or to their general practitioner, she never said a word that could be interpreted as a sign that she had stopped loving him. Mr Baker said on several occasions during the treatment that he hated his wife for her part in causing him anguish by her vacillation between him and James, and he said it with great intensity of emotion.

Even at those times his love for her was safely there, and the therapy could use it as a secure basis. Further, it is worth noting that whenever he made any progress in the understanding of his problems, no matter how slight or temporary this progress was, the response – reported as the first communication in the next session – was invariably that he and Farah had got nearer to each other and how appreciative and

grateful he was for it (see e.g. Session 2, B). The fact is that in some people this remarkable constancy of love exists and is then a most valuable ally in psychotherapy.

We think that it would not be easy to explain the character structure just described by using available theories. We must admit, however, that the treatment was rather short and thus it is thinkable that, had it gone on longer, features of intense hatred, revenge, and resentment, would have perhaps appeared. The fact, however, remains that during the length of this treatment, which enabled Mr Baker to recover from his severe illness, no such impairment of his capacity to love emerged.

Another striking feature of the case history is the absence of any hateful or resentful wishes or fantasies about James. In addition, it is noteworthy that Mr Baker did not seem to harbour any wishes or fantasies of humiliating James or, as a revenge, forcing James to beg contritely for forgiveness. Here, too, the argument of the short period of observation could be adduced, as could the fact of his very strong latent homosexuality, which would allow him to be cruel towards women but not towards a man. Nevertheless, the absence in the treatment of any such indication should be noted.

Mr Baker's emotional attitude towards his father is slightly different. Here, Mr Baker was able to experience considerable resentment, but this never developed into revengeful or hateful behaviour. True, he became more self-assertive and, as the treatment progressed, he was able to put his father into his rightful place; but he did not need any more than that. On the contrary, he was able to feel sincere sympathy and understanding towards his father when the old man felt lonely because of his wife's incapacitating illness and subsequent death.

This short sketch of some of the principal features of Mr Baker's personality includes some of the morbid trends that gradually became more and more exaggerated and formed an important part of the symptomatology of his illness. During the treatment a great deal of this could be worked through, and *pari passu* with Mr Baker's increasing understanding their intensity could be considerably reduced. Or, to use the customary terminology: the intensity of the id-derivatives was diminished and the controlling power of the ego increased. The basic structure of his personality and the habitual orientation of the id-derivatives, however, remained largely unchanged.

CHAPTER 9

Addenda

A. CRITERIA FOR SELECTION

Evidently not every patient is suitable for focal therapy. When the workshop started its research we had no clinical experience on which to found a theory for selection and in our naïvety we stipulated our criteria for selection, on the basis of preconceived ideas, as follows: the patient must be fairly young, his illness fairly recent, and he must have a fairly reliable ego-structure shown both by his achievements in life and by his ability to form lasting object-relationships. Mr Baker would score positively only on the last two criteria, but definitely negatively on the first two.

The workshop gradually recognized that our initial criteria were vague and idealistic and that, using them, one would find hardly any patients who scored positively on all of them. Malan (1963) described our developing insight into the possibilities of finding more reliable criteria and then examined statistically the validity of all our new criteria. He came to the conclusion that of all the criteria examined only two showed acceptable correlation with successful outcome. These were: (a) high motivation for coming to therapy and for insight; and (b) increase of motivation following an interpretation. Taking into account the criteria whose validity, because they were present in all the patients studied, could not be statistically examined, he described the following four criteria:

1. the patient's willingness and ability to explore feelings;
2. the patient's ability to work within a therapeutic relationship based on interpretation;
3. the therapist's ability to feel that he understands the patient's problem in dynamic terms; and
4. the therapist's ability to formulate some kind of circumscribed therapeutic plan (Malan, 1963, p. 277).

This chapter was completed by Enid Balint after Michael Balint's death.

In what follows I shall describe my subjective impressions about what I now consider to be important factors in selecting patients for focal therapy. This means that I have no statistical evidence to offer for their validity. I think it should be added that they overlap to a considerable extent with Malan's ideas, though they are not identical.

1. The patient should give the impression that he has the ability to develop eventually a workable therapeutic cooperation with that particular therapist. In other words one should be able to predict a reliable therapeutic alliance between patient and therapist that will be strong enough to withstand the considerable strains that the therapy must cause. As this description suggests, the ability to develop a therapeutic alliance should not be measured according to an absolute scale, but relative to the expected strains.
2. This factor might be called motivation. The therapist must get the impression that there is still sufficient conflict in the patient between his illness and the rest of his personality, i.e. the illness is still ego-dystonic, has not become accepted by, and built into, the ego. In other words it should appear unlikely that the patient will defend his illness as a narcissistically valuable part of his personality, that is, prefer remaining ill to changing, or even giving up parts of his personality structure.
3. The patient appears capable of accepting interpretations 'on approval', and doing some constructive work with them. This work does not necessarily amount to accepting the interpretations as valid, the patient may reject them after some constructive testing. In order to test the patient's ability, the therapist should choose during the diagnostic period interpretations that cause some considerable increase of tension.
4. The reports by the psychiatrist (therapist) and the psychologist must either confirm each other or, if not, they must make sense together. If they contradict one another or cannot be understood together, this must be considered a negative sign. This factor tests the patient's ability to make meaningful relationships with two different people in two different settings. The description of the experiences in these two object-relationships by the 'partners' (psychiatrist and psychologist) must be understandable without much difficulty by each as describing one and the same man. In other words the patient's personality is distorted by his illness but not so much that it prevents two different people from understanding him in the same way.

5. A focus should be found not later than the third or fourth session. The reason for this demand is somewhat similar to the previous one, namely, that the patient can be understood at sufficient depth and with sufficient reliability by the therapist.

I wish to repeat that these five factors or criteria for selection are based solely on clinical impressions and are in need of objective validation. I hope that this will be done in Malan's forthcoming book.

B. CHOOSING A FOCUS

As the history of Mr Baker's treatment shows, in addition to the two foci actually selected several others emerged; to mention a few – his cruelty in general and to his wife particularly, his anal interests in both primitive and sublimated form, his latent homosexuality as instanced by his feeling inferior to all other men and his envy of them, his ambivalent relationship to his father and to every superior man. All these topics appeared during the therapy and played some considerable part in it; patient and therapist had to work with them to some extent. We have to ask ourselves why it happened that none of them were considered as a focus.

I am afraid that, as yet, I have no satisfactory answer to this question and so I must be prepared to find that what I shall say about it will not satisfy my readers either. It is worth noting that in his book Malan (1963) avoided this question and what he said about it is summed up under a different concept: the 'crystallization' of a focus (pp. 210-13). The choice of this phrase suggests that our ideas at that time were that the focus was not chosen but gradually emerged out of the joint work of patient and therapist. As we shall presently see, this is partly but not entirely true.

Our experiences in the last five years or so in a research group that inquired into the possibility of what we call 'ten-minute psychotherapy' suggested to me another way of thinking about how a focus is found. The setting created by the condition of 'ten minutes' demanded a very high intensity of interaction between patient and doctor. This atmosphere helped the doctor to 'tune in' with his patient's actual mental state which is a conglomerate of hope and despair, trust and mistrust, confusion and clarity. If he succeeds in this task then it will amount to a 'flash' of understanding which usually unites patient and doctor and is felt by both. Another way of expressing this feeling is to

describe it somewhat poetically as the 'meeting of two minds' or a 'moment of truth'; expressions used by other authors, possibly describing the same experience, are the 'closing of a *Gestalt*' or the 'Aha' experience, although I am not quite sure if these latter are identical with what we are trying to describe.

The experiences of the research team, which are being written up and will be published in a separate volume, show that in the general practitioner's setting it is not necessary to express the experience of a flash in so many words. It is sufficient that the event is felt and recognized by both partners and that this recognition is kept alive in subsequent meetings. These experiences suggested to me that perhaps the dynamic process resulting in choosing a focus had something in common with a flash.

There is, however, a very important difference: in focal therapy this experience must be expressed by the therapist for his own use in fairly exact ideas, a process that is more or less identical with translating the flash experience into concise words. Without this precise formulation no focal plan can be devised, which means that the therapist will find it difficult to decide when and how to use selective attention or selective neglect. During the life of the Focal Therapy Workshop many discussions took place about how to define a focus. There was fairly general agreement that the focus must be specific (not a general idea like 'homosexuality' or the 'Oedipus complex'), sharply delineated (not as vague as 'the patient's relationship with his mother'), and unambiguous. In the later phase of our work we were much impressed by the idea that the focus should be expressed in the form of an interpretation that could be given meaningfully to the patient towards the end of the treatment. This in fact happened to one of the foci in Mr Baker's case: he became able to accept his victory over his male rival. On the other hand, the second focus, 'sharing his wife symbolically with the therapist', was never expressed in the form of an interpretation, but it was symbolically accepted by all three persons involved, i.e. Mr & Mrs Baker and the therapist (see e.g. Sessions 27 and 28).

Formulating the focus in the exact way just described demands a high degree of sensitive observation, a good knowledge of psychoanalytic theory, freedom from compulsive ways of thinking about psychopathology, and, above all, resisting the attraction of well-worn psychoanalytical phrases.

The two foci chosen in Session 2 in Mr Baker's case were: (a) to

enable him to accept his triumph over his rival; and (b) to share his wife symbolically with a man, that is, the therapist in the transference. Alternative formulations of the same idea, but described only in general terms, i.e. loosely defined, could be: 'homosexual rivalry' or 'overcoming his inferiority feelings towards men'; appropriate and specific formulations of the focus, but much more narrow: 'interest in other men's technique of love-making' or 'finding out what women feel when being made love to'; and lastly, using some attractive, well-worn, psychoanalytical phrases: 'identification with women, in particular his mother', 'passive love for men, i.e. father' or 'loving degraded women only, like mother and wife', etc. All these, and many more similar, formulations of a focus are based on correct clinical observations and make good use of psychopathological theories, but the area defined by any of them is either too wishy-washy and vague or much too narrow, both creating difficulties for the focal technique of selective attention and selective neglect. In addition, none of them could be used as a keystone of interpretation in one of the final sessions of the treatment, nor, in consequence, serve as a beacon of orientation for the therapy.

Having discussed the actual form in which the focus chosen should be expressed, let us return now to the process of choosing it. On the whole there are two alternatives. One is to rely entirely on the tuning-in. This happened in Mr Baker's case when at the end of the second session the two foci were defined exactly and remained unchanged throughout the treatment; to spell out this process – the therapist must create a climate for his patient that is free from petty mistrust and worries and thus allows the essential conflicts and areas of disturbance to emerge; this climate must be relaxed and highly intense at the same time, permitting the therapist to make observations that really matter, experience the 'flash', and translate it as just described into a concise sentence. I know that these are beautiful phrases: they mean a good deal to me but I am not sure that I have succeeded in conveying the same meaning to the reader.

The second alternative is very well described by Malan and characterized admirably by using the idea of the crystallization of a focus. This means not a flash but a gradual emergence in the give and take between patient and therapist.

What I have said up to now relates only to the initial diagnostic period, which culminates in the choice of the focus. All this is then tested and re-tested in every session of the treatment, necessitating in

certain cases a slight or considerable modification of the chosen focus, or even a complete repudiation of it. As Mr Baker's treatment shows, the therapist had on several occasions severe doubts as to whether his choice was correct and this is almost the rule in focal therapy. However, in this case the two foci survived all these vicissitudes and the treatment could be terminated with these two foci unmodified.

C. THE THEORY OF THE FOLLOW-UP

The theory of the follow-up can best be demonstrated by referring the reader to the focal aims and predictions in the session reports. From these it will be clear that at the follow-up stage the aim of the therapy was limited. This limited aim was examined. There was no criterion for cure, but only an assessment as to whether and to what extent the therapy had achieved what it set out to do. It could be argued that even if the limited aim were achieved, it might not have been achieved by the therapy. However, in view of the close scrutiny of aim, of intervention and the results of intervention, it is fair to assume that if the aim was achieved it was the therapy that had brought about the change.

Perhaps the best way of demonstrating our theory is to set out the follow-up on Mr Baker in the way in which Malan and Rayner put the questions to be answered. Their intention was to evaluate the success or failure in order to grade the different outcomes of therapy. It will be observed how much wider and more far-reaching are these questions compared to those put by Balint and discussed in the previous section of this book.

Follow-up questions on Mr Baker

1. What has been the subsequent history and what is the present position, as regards his paranoid preoccupation with his wife's relation with the other man? What is his attitude to his illness now? Have there been any other paranoid or psychotic manifestations? Has there been any change in his obsessional character?
2. Noting that two previous breakdowns occurred in association with (a) the death of a father-figure, (b) moving into a new house, and (c) buying the majority interest in the business from his father; and making the inference that these events meant triumph over father-figures:

Have there been any such events since (e.g. in this case the death of his father, major business success, etc.), and if so how has he stood up to them?

Can you get any evidence about how he stands up to situations of rivalry or threat to his masculinity?

3. How about all aspects of his relationship with his wife? Can he assert himself with her without being sadistic? (Note evidence of sadistic relations with women in Rorschach.)
4. Has there been any further evidence of latent homosexuality?

CHAPTER 10

Concluding Remarks

The reader must by now have come to some conclusions of his own regarding the similarities and differences of focal psychotherapy as compared to other forms of brief psychotherapy.

Nevertheless, we wish to make these similarities and differences explicit so as to place Balint's focal therapy in the historical sequence sketched in Chapter 2.

The two previous attempts to develop briefer forms of psychoanalytic psychotherapy both involved the use of various forms of 'activity'. These were not only to speed up and therefore shorten the therapeutic process, but they were also designed in the hope of dealing effectively with certain specific, difficult therapeutic problems, such as excessive dependency, for example.

These activities were 'manipulative' in the sense that they were used either instead of understanding and interpretation or because it was felt that such understanding and its communication to the patient would not bring about the desired results. The excessively dependent patient was not allowed to have the usual high frequency of sessions, in order to block the development of such dependency upon the therapist. Forced termination or prolonged interruptions of treatment were used for similar reasons.

One significant feature of such manipulative techniques is the fact that they were arbitrarily introduced by the therapist into the therapeutic process. A most undesirable side-effect – apart from questionable therapeutic results – of such 'non-analytic' activities is the fact that these interventions also block avenues to new observations, and thus to new knowledge, regarding those problem areas of therapy for which these activities were introduced originally.

The therapeutic processes using such active techniques were then loosely called psychoanalytic psychotherapy. Most psychoanalysts

This chapter was written by Paul H. Ornstein after Michael Balint's death.

could not accept this form of psychotherapy on a continuum with psychoanalysis. Instead they stressed qualitative and quantitative differences and insisted on viewing psychoanalysis as sharply differentiated from an amorphous psychotherapy. Many even refused to accord this form of treatment the adjective 'psychoanalytic'.

From our current vantage-point they were quite correct. Yet, we feel that the theoretical notion of a continuum would undoubtedly have enhanced the development of a form of psychotherapy that was not a diluted psychoanalysis, but was theoretically and technically on a continuum with it (Ornstein 1970a). We can now understand much better why Alexander's notion of a continuum (1956) did not find general acceptance.

It is our view that focal therapy is on a continuum with psychoanalysis, since all of the therapist's activities are restricted to interpretative interventions. The activity of the therapist consists of: (a) *finding the appropriate focus from what the patient offers*; and (b) *consistently approaching the focal problem with interpretative activity alone.* The therapist is aided in his 'selective attention' and 'selective neglect' by the focus chosen. What is not directly related to this focus is left uninterpreted (see Chapter 6).

The objection might be raised that this too is manipulative on the part of the therapist. To the extent that interpretations influence the direction of treatment, the flow of associations, the nature of what is permitted to enter into the therapeutic relationship, focal therapy is indeed more deliberately circumscribed. However, it should be stressed that the patient's associations following the interpretation chosen by the therapist may not confirm his diagnosis and therefore his focal aim may not be justified. Should this be the case, the therapist will not force the patient, by his insistence upon the interpretation, to give up the direction he himself wishes to take. The therapist does not introduce into the setting or climate of the treatment, either unilaterally or arbitrarily, any of the activities in order to short-cut understanding by both patient and therapist and to replace interpretations. This makes focal therapy analytic in its technique. Of course, the theory of treatment and of the psychopathology to be treated are also based on psychoanalytic concepts.

This claim does not do injustice to classical psychoanalytic treatment *per se*, which on one end of the continuum remains a well-circumscribed, specific, and well-delineated technique and process,

with its own particular goals and therapeutic results. The focus in focal psychotherapy undoubtedly limits the therapeutic work by design – the work in conjunction with what can be experienced and re-experienced in that relationship – thereby circumscribing, but clearly specifying and predicting, its therapeutic results.

We have one additional task in this concluding chapter: to outline briefly some areas of focal psychotherapy in need of further development and research.

1. Both the flash and the crystallization method of choosing the focus (see Chapter 9) require further elaboration and systematic study. Here, French's method of formulating the focal conflict and the nuclear conflict (which differs from the focal aim as described in this book) and his careful testing of their validity may be usefully combined. Since the chosen focus (with all the desired flexibility of changing it when required) significantly determines the course of treatment, the process of this choice along with that of the selection of patients for this form of treatment needs to be better understood.
2. Whatever else goes into the selection of patients the notion that patient and therapist 'hit it off' immediately, is significant. This process of hitting it off will have to be specified and understood in terms of both the patient's and the therapist's contribution to it. This is all the more important since the 'atmosphere' created in the treatment setting (again with contributions from both participants) will either allow and enhance or block the work on the chosen area.

In our sample treatment (Chapter 5) the session-to-session changes or fluctuations in the relationship between patient and doctor, and the resulting changes in the therapeutic atmosphere, are not as explicitly documented as we might have liked. Future research will have to focus upon this area by treating the observations regarding 'how patient treated doctor' and 'how doctor treated patient' in a much more detailed and explicit manner. This will allow the study of the atmosphere to be an integral part of the therapeutic technique.
3. We have mentioned in passing in Chapter 2 that Malan (1963) did not study the technique of focal therapy. He focused upon two other important areas: criteria of selection, and outcome and follow-ups. In this book Michael Balint wished, by presenting one sample of the technique, to point to another area that rightfully claims some priority over the others in our minds, namely the technique of therapy. We feel

that a careful study of well-documented and well-articulated techniques is necessary so that the sophisticated outcome and follow-up studies currently possible should be applied to treatments with more rigorous techniques.

This should enhance the discovery of the complicated relationship between the processes of therapy and the predictable (or even unpredictable) outcome. Without a clear link between the techniques and processes of therapy and the specific outcome, both the teachability and the researchability of psychotherapy is hampered if not made altogether impossible.

4. For the study of both technique and outcome – careful and explicit predictions from session to session and with respect to the envisaged final outcome are necessary. This is sorely neglected in the entire field of psychotherapy. Predictions and their systematic study and documentation will help us in our aim of correlating technique, process, and results.

5. The use of the forms (see Chapter 4) and their possible modifications in those areas that are under specific scrutiny can, of course, aid us in the systematization of our observations in all areas mentioned in the four preceding sections. One modification now being planned (by PHO) is the independent, but simultaneous use of tape-recordings and the forms. The latter would be filled out by the therapist without the use of the tapes so that both kinds of documentation should be available for research and teaching.

The two extremes of the continuum we have talked about, psychoanalysis and focal psychotherapy, are, comparatively speaking, well defined. What lies between these two extremes, the amorphous 'psychoanalytic psychotherapy', can perhaps also develop into a well-defined treatment modality if we approach it on the basis of what we have learned from classical psychoanalysis and from focal psychotherapy.

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